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Development of the Dynamic Model of Occupation-Based Practice

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Development of the Dynamic Model of Occupation-Based Practice

Abstract

Background: Occupation-based practice is unique to occupational therapy, supported as effective in the literature, and promotes health and well-being for clients. There is no framework describing what occupation-based practice looks like, making the goal of infusing occupation into practice difficult. This research study aimed to develop a model of occupation-based practice, providing a framework with constructs, facilitators, and barriers for using occupation in practice.

Method: A grounded theory study was completed with interviews and a focus group. Charmaz's approach to grounded theory was used to analyze data and allow a model to emerge.

Results: The dynamic model of occupation-based practice emerged with four constructs, including actual occupation, meaningful and purposeful value, therapeutic intent, and engaged participation. The model explains the ever-changing process of therapeutic interactions depicting the essence of the interaction along a continuum between a discrete model and occupation-based practice.

Conclusion: The model derived from this study offers a framework to operationalize the approach to occupational therapy practice espoused by the profession's leaders and theorists to provide uniquely occupational services. This model can inform the profession at the practice, academic, scholarly, and administrative levels to support enhanced practice, evaluate programs, and study occupation-based practice.

Comments

No authors or contributors to this study have financial or non-financial relationships, activities, or conflict of interest based on the study design, materials used, or outcome of the research.

Keywords

grounded theory, model, occupation, occupation-based, practice

Cover Page Footnote

The origin of this work was a dissertation study in partial completion of a Doctor of Philosophy in Occupational Therapy by the first author. The authors would like to acknowledge the other committee members for their contribution to the original study: Dr. Eli Stav and Dr. Elizabeth Francis-Connolly. This was an unfunded research study. This study was presented at the Connecticut Occupational Therapy Association in March 2020 and was published as an abstract in the American Journal of Occupational Therapy in August 2020.

Credentials Display

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From the inception of the profession of occupational therapy, a central and foundational belief has surrounded occupation and its relationship to health (Christiansen & Haertl, 2014; Meyer, 1921; Molineux, 2004; Moyers, 2005). The construct of occupation is defined as everyday personalized activities in which people engage to occupy time and bring meaning and purpose to life (American Occupational Therapy Association, 2020). Occupations provide personal and cultural meaning; are affected by context; change over time; influence identity, health, quality of life, and relationships; and require adaptation (Price & Miner, 2007). Wilcock and Hocking (2015) further elaborate on the contribution of occupational engagement to health through the concepts of doing, being, becoming, and belonging. When occupation is intentionally used in practice as the foundation for the therapeutic process to reach occupational outcomes, it is referred to as occupation-based practice (Fisher, 2013).

While the profession has gone through multiple paradigm shifts, the initial assumptions remain: (a) that occupation is vital to human life, (b) that there is a direct link between the mind and body, (c) that a lack of occupation can result in poor health or dysfunction, and (d) that engagement in occupation can re-establish health and function (Molineux, 2004). Throughout the past century, the belief that occupation serves as a means and end to improve health has waxed and waned, and the current paradigm is moving back to the foundational philosophical beliefs (Christiansen & Haertl, 2014; Gillen, 2013; Gray, 1998). However, even with the encouragement of leadership and professional associations to transition back to an occupation-based approach, there continue to be questions and inconsistencies about how occupation is infused into practice.

Over the past 100 years of the profession of occupational therapy, there has been the waxing and waning of the central concept of using occupation throughout the therapy process despite theoretical frameworks depicting occupation as a means to healing and good health (Christiansen & Haertl, 2014; Gillen, 2013; Gray, 1998; Hocking, 2009; Wilcock, 2006). A review of the current literature revealed evidence that supports the use of occupation-based practice with a variety of client populations. While research supports the use of occupation-based practice, the implementation is inconsistent, and further exploration into the composition of occupation-based practice and the relationships between the constructs is necessary.

History of Occupational Therapy and Philosophical Transitions

The use of occupation is evident as early as the Greeks, who engaged in occupation to provide educational training and for its therapeutic value (Dunton, 1954). At the end of the 18th and beginning of the 19th centuries, many hospitals used occupation to assist those with mental health difficulties. By the early 1900s, a new profession was being formed based on the healing value of occupation (Reed & Peters, 2006). In the profession's infancy, the term occupation was used most predominantly, however, it transitioned to activities and work in the 1930s and 1940s (Bauerschmidt & Nelson, 2011; Reed & Peters, 2006). At this time, a medical alliance was spawned when the American Medical Association became the accrediting body of the field (Reed & Peters, 2006). The profession was grouped with physical therapy and was given the second priority when it came to billing (Reed & Peters, 2006). Significant growth in the profession following World War II sparked a rise in rehabilitation, physical medicine, and adoption of medical model practices (Christiansen & Haertl, 2014). In the 1950s and 1960s there were changes in medicine and social reform in the United States, resulting in alignment with scientific methods, engagement in research, and reliance on third party reimbursement (Reed & Peters, 2007). This drove therapists further toward the medical model, which used mechanistic approaches focused on the parts of clients rather than their wholeness as occupational beings.

In the 1970s and 1980s, the profession committed to research and establishing a professional identity, developed standardized measurement tools and models of practice, and drafted guiding official documents. Despite this growth, the profession still wavered the professional focus between the medical model and a move back to a holistic occupation-based perspective (Reed & Peters, 2008). By the end of the 20th century, the medical model practice patterns and loss of professional identity served as a catalyst for an occupational renaissance with renewed attention to occupation in theoretical development, research, and practice (Whiteford et al., 2000). Upon entering the 21st century and the centennial anniversary of occupational therapy, professional organizations and the academy reached consensus with a shared vision to return to the holistic and occupation-based roots of the profession (Molineux, 2004). While the leaders of the profession support a full return to occupation, there has been a lag in the adoption of occupation-based approaches by therapists because of several contributing factors making it difficult to do so daily with clients. The delay in endorsement of occupation-based approaches by therapists can be explained by the diffusion of innovation theory that depicts the incremental adoption of new ideas and technologies (Rogers, 2003).

Effectiveness of Occupation in Practice

Considering the trend toward and acceptance of occupation-based practice, research examining its effectiveness is increasingly prevalent in the literature. Current literature broadly supports the use of occupation in practice yielding positive outcomes throughout a variety of settings and client populations. The following systematic reviews depict the abundance of studies revealing the effectiveness of occupation-based approaches across several client populations. D'Amico and colleagues (2018) found that interventions focused on ADL, IADL, leisure, and social participation resulted in improved outcomes among individuals with serious mental illness. A systematic review of activity- and occupation-based interventions used with children with mental health disorders revealed significant improvement in the areas of mental health, social participation, and behaviors (Cahill et al., 2020). Another systematic review examined social emotional learning with children and youth and found activity- and occupation-based interventions to be effective in improving social emotional learning, stress management, self-management, and social behavior at all three levels (universal, targeted, and intensive; Arbesman et al., 2013).

Several studies of occupational therapy practice effectiveness with adult clients were critiqued for systematic reviews and revealed positive outcomes when occupation was used therapeutically. Smallfield and Heckenlaible (2017) found that individuals with dementia who participated in activity- and occupation-based interventions benefited with reduced cognitive decline, improved occupational performance, and enhanced behaviors. A similar review of the effectiveness of activity- and occupation-based interventions with clients who sustained a stroke highlighted results indicating improvement in cognitive performance, ADLs, and leisure (Gillen et al., 2014). The evidence reviewed in these systematic reviews encompassing 345 individual research studies emphasize the importance of using occupation-based approaches in clinical practice. Additional systematic reviews have revealed the same trend of enhanced outcomes following the use of occupation-based approaches in individuals recovering from traumatic brain injury (Powell et al., 2016), and clients with acute and chronic hand injuries (Robinson et al., 2016).

While a preponderance of evidence supports the effective use of occupation as a therapeutic medium, it is difficult to infuse occupation into practice effectively when there is no consensus on what occupation-based practice looks like. Therefore, this study sought to discover a better understanding of occupation-based practice, specifically the constructs of occupation-based practice, and how those constructs are interrelated. The study aimed to answer the following research

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questions: (a) What is occupation-based practice, and what does it look like? (b) What are the constructs that make up occupation-based practice, and how are they interconnected? and (c) What are the facilitators and barriers to using occupation-based practice?

Method

This grounded theory (Richards & Morse, 2013) study was designed to glean from occupational therapists how to comprehend occupation-based practice based on their experiences with the intention of developing a model from the data gathered. This study was guided by Wilcock and Hocking's *An Occupational Perspective of Health* (2015), which delineates the doing, being, becoming, and belonging of occupation. The doing construct connotes engagement in occupation, whether mental, physical, social, communal, spiritual, restful, active, obligatory, self-chosen, and paid or unpaid; while the being construct refers to the meaning, essence, and spirit associated with or derived from doing (Wilcock & Hocking, 2015). Becoming refers to the outcome of a trajectory as one develops, transforms, becomes more knowledgeable or mature, realizes aspirations, or achieves potential (Wilcock & Hocking, 2015). The final construct of occupation contributing to health, belonging, is more longitudinal in nature and suggests an affiliation, association, or connection to others, being a member or part of something, being in the right place, and feeling right and fitting in (Wilcock & Hocking, 2015). The study design was reviewed and approved by a university institutional review board for adherence to ethical research practices.

Participants and Settings

A purposeful sample was used in this study to analyze a broad and rich data set (Benoot et al., 2016) recruited through convenience and snowball sampling techniques. Licensed occupational therapists were considered for inclusion in the study if they passed the national board exam, had a minimum of 1 year of clinical experience, and worked full-time. Potential participants were identified by their membership in a university fieldwork educator database from an occupational therapy program in the New England region of the United States. Occupational therapists from a range of practice settings with Student Evaluation of the Fieldwork Experience (SEFWE) forms that included interventions identified heavily as occupations and activities were invited to participate in the study. Following recruitment, an email invitation to participate in the study was sent to each eligible therapists. Ten occupational therapists were eligible and agreed to participate in the study; six participated in interviews and four met in a focus group. In accordance with the protection of human subjects per the university-approved institutional review board, interested participants who responded to the research invitation completed the informed consent process, and interview appointments and locations were established. The interviews and focus groups, which were selected by the participants, all occurred in quiet rooms in a location convenient and comfortable for the participants or online. The participants chose locations such as their homes, workplaces, the researcher's workplace, or an online video conferencing platform.

Procedures

Data collection with each participant began with a demographic questionnaire specific to self-identified gender, highest earned degree, years of clinical experience, and current and past practice settings. In-depth interviews were conducted using a semi-structured interview schedule and digital audio recording device to ensure accuracy of the participants' statements. A focus group was facilitated with a different group of therapists using a discussion guide and digital audio recording device to distinguish participant statements and ensure accuracy. Following each data collection session, the primary researcher completed a memo and each interview transcript was transcribed verbatim from the digital recordings.

Data Analysis

Data analysis used Charmaz's (2014) grounded theory approach, which occurred simultaneously with data collection. This method begins with inductive data and continues to transition back and forth between the data and analysis to compare findings and continue to gather data until reaching saturation. Charmaz's grounded theory provides general guidelines to formulate a theory. These steps include: (a) writing a research question, (b) participant recruitment and sampling, (c) collection of data, (d) initial coding, (e) focused coding and categorizing, (f) theoretical coding, (g) building of theory, and (h) dissemination of findings (Charmaz, 2014).

All analysis was performed using NVivo (QSR International, 2017) qualitative analysis software to manage the data and coding. Recruitment and data collection continued until data saturation was reached.

The data analysis began with a process of reflection and coming clean in which the primary researcher identified her personal background and beliefs to allow for transparency or reflexivity. The interests, positions, and assumptions were identified as being strongly grounded in occupation as an agent of health and healing. This process of intentional and explicit acknowledgment of the researcher's perspective and continued use of field notes and writing a memo allowed for bracketing of this perspective for unbiased analysis of the data.

Line-by-line coding was completed with specific attention to how the participants defined occupation, the way they practiced, their thoughts and beliefs about occupation, how well they felt they used occupation-based practice, and positive and negative experiences with occupation in practice. An external reviewer also coded a portion of the data to ensure credibility and reduce researcher bias. Codes were combined based on similarity of sentiments into 15 categories. The categories that reflected the way therapists were practicing, such as use of occupation, clinical reasoning, therapeutic use of self, grading and adapting, and assessment and evaluation, were combined as the first theme emerged. Categories focused on the unique contribution of occupation to the care of clients, such as the explanation of occupational therapy and defining occupation, emerged as the second theme. The remaining categories, related to factors that influence the implementation of occupation-based practice, formed the third theme and included the practice settings, facilitators, and barriers. From these groupings of categories, three themes emerged from the data.

Findings

The participants received a demographic questionnaire, and eight participants completed it. Demographic information for the eight participants can be found in Table 1.

Table 1

Participant Demographic Information

Demographic	Male	Female
Self-Identified Gender	1	7
Self-Identified Ethnicity		
White/Caucasian	1	6
Hispanic	0	0
Highest Earned Degree		
Bachelor's	1	1
Master's	0	6

Note. Two participants did not complete the demographic questionnaire.

The participants' ages ranged from 28 to 42 years of age, with a mean of 34 years of age. Each participant in the study passed their board certification exam in the past 2 to 18 years and had practiced clinically between 1.5 to 18 years. The participants' practice settings included the school system, adult subacute rehabilitation, adult home care, and geriatric home care. Their collective prior clinical experience included practice in school systems, paediatric outpatient, adult acute care, adult subacute care, adult and geriatric home care, geriatric mental health, and military mental health.

The participants clearly provided descriptions and examples as to what occupation-based practice looks like in a variety of settings. After the completion of initial and focused coding, the researcher further examined the categories guided by the constructs from *An Occupational Perspective of Health* (Wilcock & Hocking, 2015) and *Diffusion of Innovations* (Rogers, 2003). Three main themes emerged: (a) facilitating doing, being, and becoming; (b) professional identity; and (c) facilitators and barriers to use of occupation-based practice. From the analysis process and resulting themes, the researchers generated a comprehensive picture of occupation-based practice. Specifically, the process of facilitating doing, being, and becoming depict the aspects of therapeutic interactions that constitute occupation-based practice, including participation in actual doing, which is meaningful and purposeful to the client and intentionally therapeutic. Similarly, the facilitators and barriers represent the professional and contextual influences on each therapeutic interaction and, ultimately, occupational therapy practice. Through the analysis process, constructs of occupation-based practice and a model emerged from the data.

Constructs

Occupation-based practice consists of four main constructs: authentic occupation, engaged participation, meaningful and purposeful value, and therapeutic intent (see Figure 1). Each construct can be executed in varying degrees of alignment with occupation-based practice. Authentic occupation, the first construct, reflects Wilcock and Hocking's (2015) doing, and represents the actual doing and use of activities. When authentic occupation is used to the fullest extent, a client may perform showering, driving a car, or crocheting as a therapeutic approach. A therapeutic approach partially aligned with authentic occupation may involve performing one element or simulation of an occupation, such as squatting to work toward laundry management or stepping in and out of a bathtub to simulate a shower transfer. Performing rote exercise as a therapeutic approach represents misalignment with the authentic occupation as it does not involve actual doing of an occupation.

The second construct, meaningful and purposeful value, reflects Wilcock and Hocking's (2015) being and is related to having an objective for doing as well as the extent of value assigned to the therapeutic intervention by the client. Presence of meaning and purposeful value relies on selection of therapeutic approaches based on the client's personal values. Complete alignment with meaningful and purposeful value may incorporate pet care or playing a musical instrument into the therapeutic process because they involve an objective as well as being client driven. Partial alignment may involve a therapist selecting a cooking activity for a client who lives in a residential facility where all meals are provided. While the activity has an objective, it is not meaningful for the client. Therapeutic approaches that are not aligned with meaningful and purposeful value are exercises that may include range of motion arcs or hand bikes as it generates no meaning and does not accomplish an objective.

The third construct, therapeutic intent, reflects Wilcock and Hocking's (2015) becoming and is the deliberate selection of approaches for a goal-directed therapeutic process to address the client's areas of need as clients complete the healing process or evolve into their new identity. If an activity is fully aligned with therapeutic intent, the therapist may select a cognitive puzzle to address the

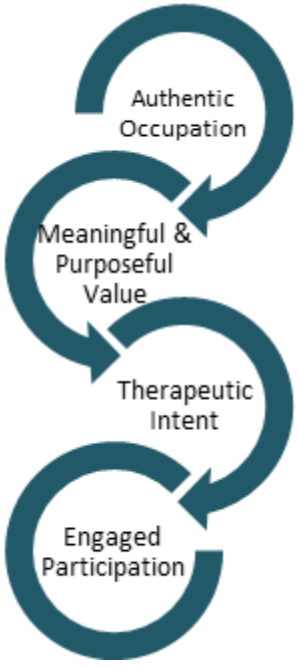
problem-solving deficits associated with a client's traumatic brain injury. A therapeutic interaction partially aligned with therapeutic intent could involve a therapist facilitating a guided imagery exercise to support a client to tolerate dressing changes to his burn sites. While this exercise may be beneficial to the client, it does not specifically progress him toward his occupational goals. Circumstances with no alignment of therapeutic intent may occur when a therapist is satisfying a requisite number of billable minutes rather than addressing the client's goals. For example, a school-based therapist seeing a child in a weekly handwriting group who has executive function and feeding goals would not be aligned with therapeutic intent.

The final construct of occupation-based practice is engaged participation, which reflects the facilitation aspect of the first theme and refers to the therapist's support of the client's participation with full investment and motivation during a therapeutic interaction. A therapeutic interaction that is fully aligned with engaged participation may include a teenager competing against his high bowling score using a motion-activated gaming system. Partial alignment may occur when a client is assigned to a cooking group and intermittently attends to and participates in the cooking tasks. When there is no engaged participation, the client is the passive recipient of a therapeutic approach, such as receiving ultrasound to a post-surgical scar.

The final aspect of Wilcock and Hocking's (2015) work, belonging, was intentionally excluded from the dynamic model of occupation-based practice as belonging depicts the outcome of a longitudinal pathway to health. This model reflects each therapeutic interaction as a snapshot of practice rather than the longitudinal trajectory toward health.

Figure 1

Constructs of the Dynamic Model of Occupation-Based Practice

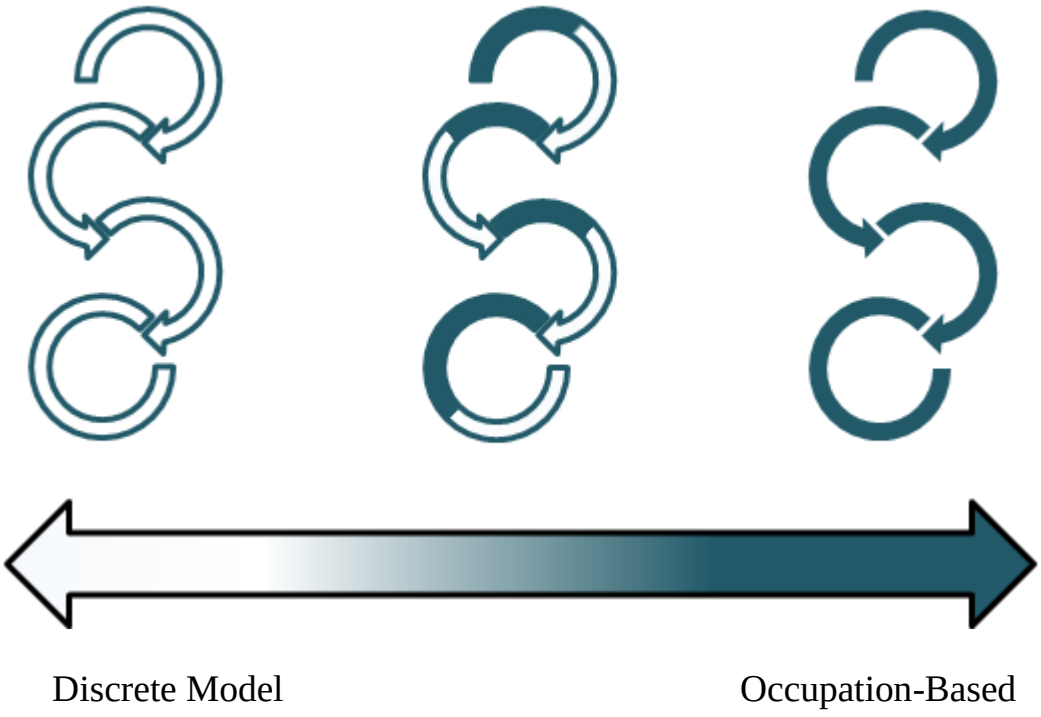


During every therapeutic interaction, each construct is independent, without influence from the other constructs. While the constructs have no direct influence on each other, there is an interconnectedness between them. For example, a person is more likely to have engaged participation in an activity that has meaningful and purposeful value. Likewise, the use of authentic occupation tends to have meaningful and purposeful value, as opposed to the repetitive movements of an exercise. Analysis of a therapeutic interaction considers the extent of alignment in all four constructs collectively. For any therapeutic interaction, each of the four constructs are mutually

exclusive and may be similarly aligned or have vastly different alignments from the other constructs. Therefore, there are infinite possibilities and combinations based on the extent of alignment to each of the constructs. Thus, when considered collectively, the greater the cumulative alignment, the closer the therapeutic interaction is to occupation-based. Conversely, the less collective alignment with the constructs, the less focus on occupation and greater emphasis on an approach that is discretely different. These discrete models follow an agenda other than health through occupation and may be influenced by a medical focus, educational requirement, psychological perspective, business model, military priority, complementary or alternative medicine, or any other compelling authority. When the model is applied in therapeutic interactions, the practice that is discretely different from occupation-based should be labeled in accordance with the focus of the context. For example, the discrete model of practice in an acute care hospital may be a medical model, while the discrete model in the school system may be an educational model. This result of the cumulative alignment of the four constructs is depicted in Figure 2.

Figure 2

Continuum of Occupational Therapy Practice Influenced by Construct Alignment



Influential Factors

The extent of alignment of each individual construct and the combined profile of constructs does not occur by happenstance; rather, the alignments are a result of the influence of several personal and contextual factors that either facilitate or inhibit occupation-based practice. The final theme that emerged from the study reflected the therapists' identification of several factors influencing their ability to use occupation-based practice, some of which fostered the use of occupation while others prevented the integration of occupation. These individual factors were then combined during the qualitative data analysis resulting in four components: client, therapist, systems, and physical environment. Some influential factors function as both facilitators and barriers depending on the circumstances or context.

The systems factor is typically determined by the organizational and institutional context of the workplace and are often not choices a therapist is able to make but are predetermined. The systems factor includes allowable reimbursement from third-party payer sources, documentation systems and requirements, and time availability. The influence of a third-party payer may be a barrier, as in the case of insurance restrictions that could limit the ability to provide services in an occupation-based manner. Conversely, the open-ended funding system of school-based services can facilitate integration of occupation into practice. Documentation systems and requirements therapists must use and follow can serve as barriers, as many systems have preset choices that are not occupation-based and not alterable. The last component in the system's influence is time, which can be viewed as both enhancing and inhibiting, depending on the workplace and situation. Time can be a facilitator if there is flexibility in a therapist's schedule, but can also serve as a barrier with the high productivity requirements and large caseloads.

The physical environments specific to the location, space, and presence or absence of supplies and resources can enhance or inhibit the infusion of occupation into practice. Location can facilitate the use of occupation-based practice, especially when in the client's own home as opposed to a hospital or unfamiliar setting, which can prevent use of occupation. The space of an environment may facilitate or hinder the use of occupation depending on whether there is enough area to execute occupations or if the setup is safe and an ideal configuration. The other component of the physical environment is resources and supplies. Access to occupation-based equipment and supplies promotes the infusion of occupation throughout therapeutic interactions. For example, the presence of occupation-based kits, a mock grocery store, and an adapted car are easily integrated into therapy sessions. However, when therapists do not have access to resources and supplies, it can be challenging to use occupation-based practice, and thus it becomes a barrier.

Clients themselves influence the inclusion of occupation into practice based on their health status, the complexity of their role responsibilities, and their motivation. If a client has multiple contributing health conditions it may be challenging to use occupation-based practice, since the client may be focused on survival rather than meaningful engagement, or unable to participate fully in therapy. When a client has complex roles to which they need to return, it can be difficult to therapeutically replicate the occupations and contexts of those complex roles. Finally, client motivation can serve as a facilitator with clients who envision themselves as occupational beings and are driven to return to healthy engagement, while a lack of client motivation or vision may limit the willingness and be a barrier to participation in occupation.

The influential factor of therapist includes several aspects of the professional role, including therapist experience, clinical reasoning skills, intraprofessional collaboration, therapist-client fit, and relevant others. The contribution of therapist experience can function as a facilitator or barrier based on their education or work experience supporting occupation-based practice where they were able to use occupation-based practice. Clinical reasoning and intraprofessional collaboration can facilitate or hinder the inclusion of occupation in practice. The therapist-client fit is another aspect of the therapist factor that can influence occupation-based practice based on the presence of a cohesive therapeutic relationship, and includes rapport, or similar therapist-client characteristics, such as self-identified gender, race, ethnicity, hobbies, geographic origins, or religion. Finally, the presence of relevant others, such as family members or caregivers, can assist in therapeutic interactions allowing more complex occupations to be performed in practice.

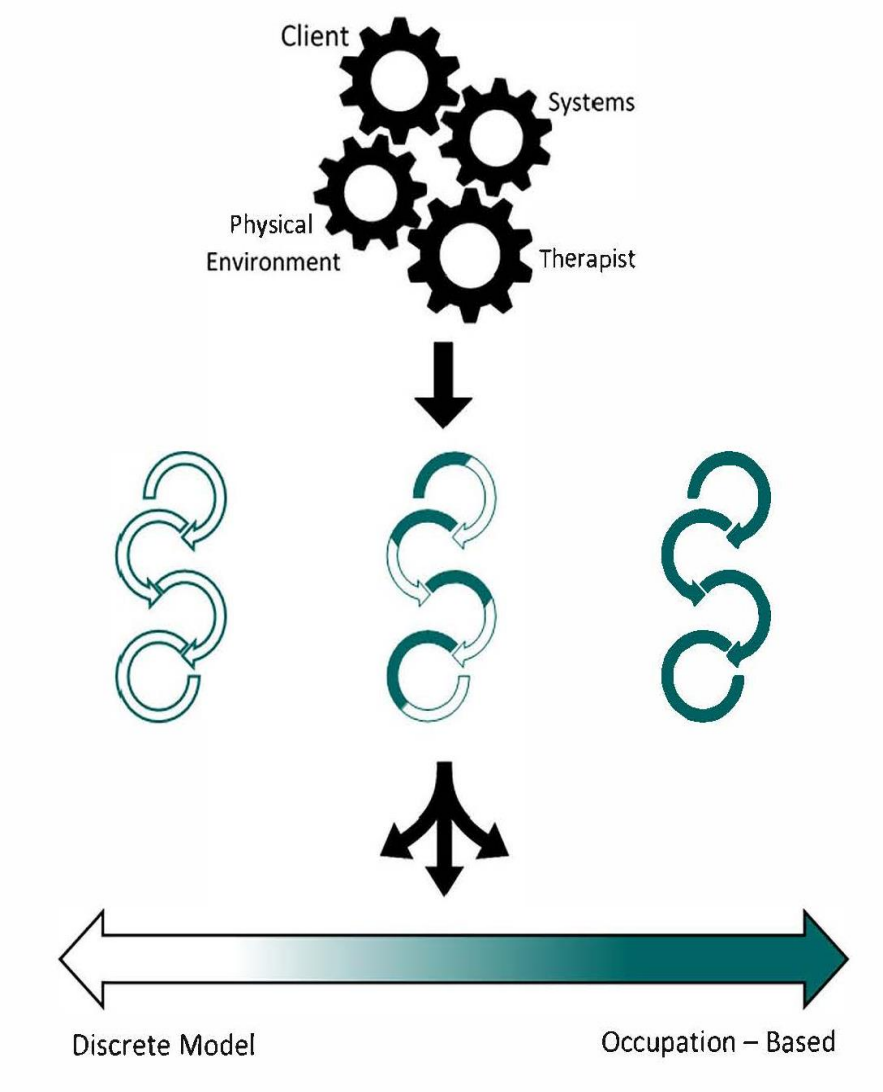
Dynamic Model of Occupation-Based Practice

A model depicting the process of influences on occupation-based practice emerged as the dynamic model of occupation-based practice. Figure 3 depicts the process of how the influential

factors and occupation-based constructs contribute to where along the spectrum each therapeutic interaction lies.

Figure 3

Graphic Depiction of the Dynamic Model of Occupation-Based Practice



This model explains the influences, process, and essence of therapeutic interactions in occupational therapy practice. The model includes several assumptions as existing beliefs about the occupational nature of humans, the relationship between occupation and health, occupational therapists, and professional practice. The dynamic model of occupation-based practice assumes that humans are occupational beings who have a need and desire to engage in meaningful occupations. The reciprocally beneficial relationship between occupational engagement and health is foundational to the model and supports the need to use occupation as a therapeutic approach. The model also assumes occupational therapists possess a foundational belief about client care that is either more or less aligned with occupation-based approaches. This foundational belief system is dynamic and ever changing; and while it is built on the therapist's education, work experience, and personal alignment with the profession's philosophical assumption, it can shift and respond to professional growth or contextual influences. Finally, while the use of occupation in practice is ideal to restore health, the course of therapeutic interactions, both assessment and intervention, consists of a necessary mix of discrete models and occupation-based approaches. The integration of discrete models into

occupation-based practice is necessary to address health, safety, and third-party requirements. For example, therapists must observe and educate about contraindications, perform dressing changes for infection prevention and healing, and measure range of motion to justify the need for services and achievement of outcomes even though these interactions are not occupation-based.

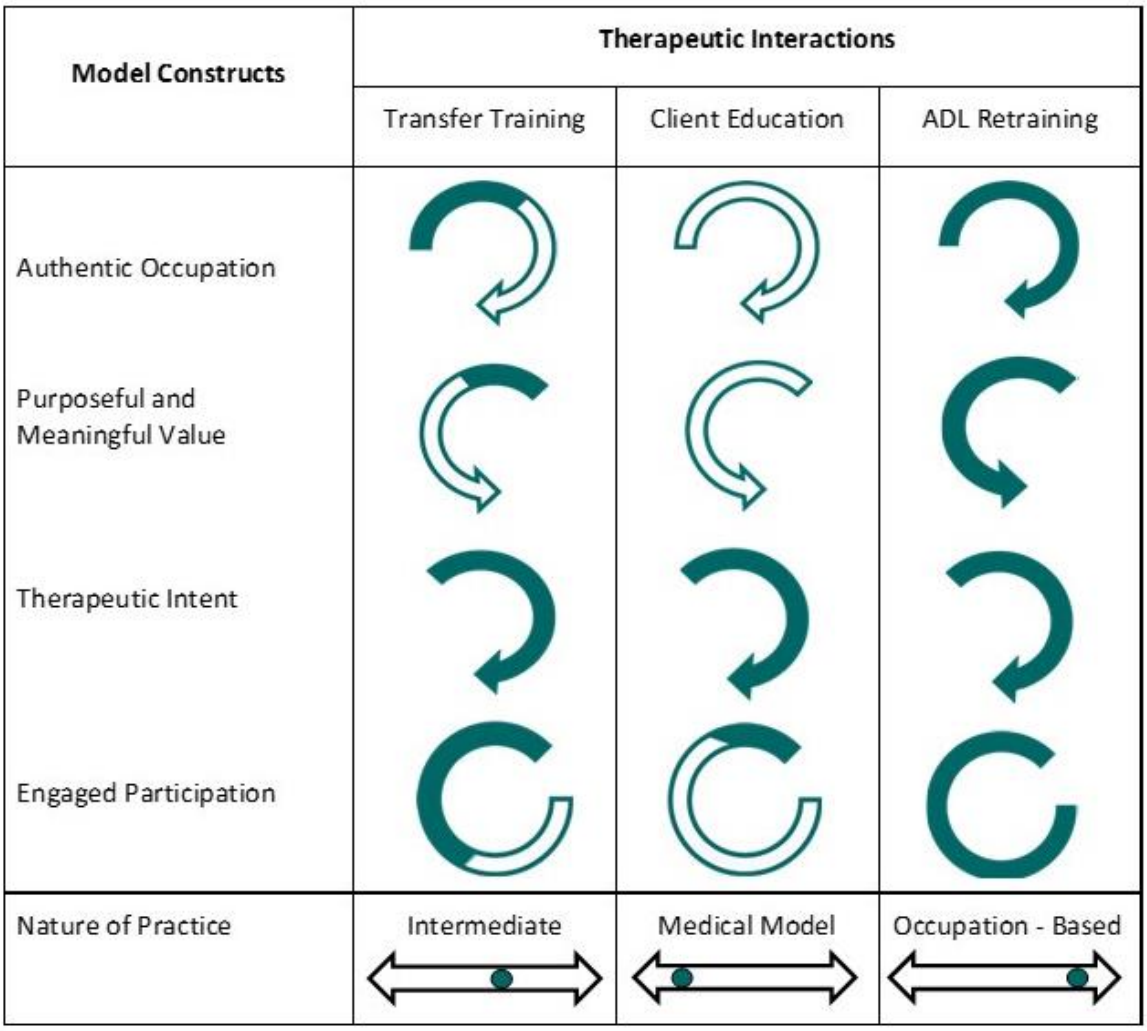
Progression through the dynamic model of occupation-based practice begins with the therapist's foundational belief system related to occupation and the therapeutic use of occupation. From this starting point, each therapeutic decision and execution is acted on by four influential factors, including systems, therapist, physical environment, and client. The factors, represented by the four interlocking gears at the top of the graphic, are interrelated and may be different from one therapeutic interaction to another. The influence of the factors may enhance the use of occupation, hinder the use of occupation, or may fluctuate depending on the circumstances. The factors influence the model's constructs that then affect the extent of alignment in each construct and ultimately determine the combined profile of the constructs. The influence of the factors and combined profile results in the essence of the therapeutic interaction either toward a discrete model or occupation-based practice. The continuum of occupational therapy practice is represented by a double-sided arrow, the extremes of which are a defined discrete model and occupation-based practice. Each therapeutic interaction with and between clients dynamically exists along the continuum.

Case

An example of application of the model is a therapist working in an acute care hospital who has a strong foundational belief in occupation. At the hospital, the electronic medical record documentation system has pull-down menus of medically based goals and a rehabilitation gym supplied with biomechanical assessment tools and exercise equipment. A client with a recent total hip replacement must be treated in their hospital room because of contact precautions associated with a communicable infection. The client stated during the evaluation that they want to appear "put together" when their daughter comes to visit. The morning occupational therapy session was planned to focus on dressing so the client would be presentable when their daughter arrived. Upon entering the room, the occupational therapist noted the client was still in bed, so the session began with bed mobility and transfer training in preparation for dressing. The therapist instructed the client in proper hand and leg placement to safely roll and transfer out of bed. After observing contraindicated lower extremity movements, the therapist dedicated time to provide education about total hip precautions and the implications while engaging in occupations throughout the day. The remainder of the session focused on dressing retraining using adaptive equipment while observing the orthopaedic precautions. At the end of the session, the client expressed satisfaction and pride in being able to manage donning their own clothes, socks, and shoes and was eager to greet the expected visitor. An analysis of the constructs comprising each therapeutic interaction described in the case is depicted in Figure 4.

Figure 4

Analysis of Constructs in Therapeutic Interactions



Discussion

This grounded theory study delineated the constructs of occupation-based practice and described how the four constructs combine to determine the nature of practice along a continuum between a discrete model and occupation-based. The factors influencing practice contributed to the emerged model, providing a concrete depiction of occupation-based practice. The dynamic model of occupation-based practice illustrates the dynamic and ever-changing process that occurs during each therapeutic interaction between a client and an occupational therapist. The model that emerged provides and defines the four constructs comprising occupation-based practice that are present to varying degrees in every therapeutic interaction. The model also acknowledges the influential factors that facilitate and hinder the use of occupation-based practice. The culmination of the influential factors and extent of presence of each construct falls along a continuum between a discrete model and occupation-based for each therapeutic interaction. This is one of the first frameworks in the occupational therapy literature describing the process of occupation-based practice.

Implications for Practice

The model provides a framework of occupation-based practice that functions to distinguish occupational therapy services from other professions for clients, members of the health care team, administration, and third-party payers. The differentiation through occupation-based practice highlights the unique contribution of occupational therapy to the care of clients and reduces ambiguity related to duplication of services. This new model is an asset to therapists as it can provide

a structure to practice and distinguish clinical services from other disciplines to portray the distinct value of occupation. The structure of occupation-based practice allows therapists, academicians, and researchers the ability to operationalize and inform practice, professional development, education, and research.

Awareness of the constructs of occupation-based practice can promote professional development among therapists. The model offers clarification and areas of potential enhancement for professional development toward occupation-based practice. This model can evolve individual and collective professional practice to exemplify the foundational philosophical beliefs that occupation is health promoting as described by Gillen (2013), Meyer (1921), and Molineux (2004). In addition, the benefit of occupation-based practice is enhanced client outcomes and potentially optimized client satisfaction, which further supports the health-promoting effects of occupation as summarized in several systematic reviews (Arbesman et al., 2013; D'Amico et al., 2018; Smallfield & Heckenlaible, 2017).

Optimal implementation of occupation-based practice necessitates attention to the four constructs so collectively they can yield practice skewed toward occupation. Provision of occupation-based practice requires a context that allows for authentic occupation. To accomplish this, services should use occupational materials, take place in a context consistent with occupation, and involve actual doing of a task or partial task. To facilitate therapeutic interactions that are purposeful to a client, therapists must identify and use occupations that are meaningful to the client. Satisfying therapeutic intent requires therapists to intentionally select approaches to address areas of need and offer modification of the context or task to create the just-right challenge. The therapist can foster engaged participation in the therapeutic process through dynamic collaboration with clients to actively enlist their involvement in the process.

This model also has multiple implications for the manner in which we initially and continuously train occupational therapists. The model could be used as a framework for professional-level students while establishing a foundational paradigm grounded in occupation. Integrating the model as a thread conceptualizing occupation-based practice will support learning about client assessment, intervention planning, and determination of outcomes. The constructs and structure of the model can also be used as baseline, formative, and summative assessments of students' knowledge and skills during didactic coursework, assignments, practical exams, and practice education.

Professional development can be augmented by the dynamic model of occupation-based practice by reconnecting therapists to the philosophical base of the profession and providing a new lens through which to understand the therapeutic use of occupation. This model can counter the habituated reductionistic practice patterns of seasoned clinicians by reintroducing them to the importance of meaning, context and materials, participation, and doing in the restoration of health. Therapists can use the model to understand and achieve the standard of occupation-based practice set by professional organizations around the world as outlined by professional guidelines, philosophical and theoretical leaders, as well as the World Federation of Occupational Therapists.

Limitations and Future Research

While this study used the structure and guidelines of the grounded theory approach, there are still areas that could be improved. The purposeful sampling used in this study included recruitment from school systems, early intervention, rehabilitation hospitals, and home care with the hope these settings would yield therapists who use occupation. The unintended consequence was the exclusion of therapists from several other settings and their perspectives. Another limitation of this study was the lack of exploration about extent, concentration, frequency of the use, or perceptions of expertise

in the use of occupation in practice. A final limitation of this study related to personal bias. The researchers used multiple strategies to remove personal bias by engaging in reflexivity with the acknowledgment of those biases prior to the study beginning and the use of memos to document personal thoughts and beliefs throughout the stages of the research study. However, because of the embeddedness a researcher has when using the grounded theory approach, it is difficult to determine if all biases were completely removed.

While this study answered the posed research questions, further inquiry is needed to test the model developed from this study to enhance and confirm or challenge the findings of this research. Additional exploration of the dynamic model of occupation-based practice should include quantifying the extent and frequency of occupation-based practice. Using the model to quantify occupation-based practice could be useful in moving therapists more in line with occupational therapy core philosophies and toward the vision of the profession. Current research is in progress to develop a measurement tool allowing therapists and administrators to determine whether and how frequently therapists are using occupation-based practice in a variety of settings. Such an assessment tool can be used for measurement of student learning in the therapeutic use of occupation during practice experiences, standardization for simulation, program evaluation, correlation with client satisfaction, baseline and progress in therapists' professional development, and research to determine the effectiveness of occupation-based approaches.

Conclusion

The dynamic model of occupation-based practice identifies the four major influences on the inclusion of occupation in practice as systems, physical environment, therapist, and client. The model further distinguishes the four constructs comprising occupation-based practice as authentic occupation, meaningful and purposeful value, therapeutic intent, and engaged participation. Consideration of the impact of practice influences and the extent each construct is implemented determines the essence of the therapeutic interaction along the practice spectrum from a discrete model to occupation-based. The implementation of this model can inform practice, education, professional development, and future research.

This model can help therapists exemplify practice that is uniquely occupational to further distinguish themselves from other professions, alleviating the long-standing professional identity issues acknowledged by Gillen (2013). A new model describing occupation-based practice can contribute to the occupational renaissance described by Whiteford et al. (2000), which began at the end of the 20th century when reductionistic practice patterns and loss of professional identity were replaced with renewed attention to occupation in theoretical development, research, and practice.

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