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## An Occupation-Based Clinic Makeover: Perceptions and Experiences of Occupational Therapists

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# An Occupation-Based Clinic Makeover: Perceptions and Experiences of Occupational Therapists

## Abstract

*Background:* Researchers sought to discover the experiences of occupational therapists transitioning from existing clinical practice to exclusively occupation-based approaches.

*Method:* This phenomenological study captured the experiences of clinicians as exercise-based equipment was temporarily removed from the rehabilitation gym and replaced with occupation-based kits. The therapists used the new occupation-based materials with all clients for 4 months and participated in interviews and a focus group.

*Results:* The study yielded a greater understanding therapists' process and experiences through the themes: (a) challenges to occupation-based practice and (b) occupation-based metamorphosis.

*Conclusions:* The personal and contextual obstacles associated with implementing occupation-based practice hinder occupational therapists' abilities to practice aligned with the profession's philosophical beliefs. However, when sufficient supports are in place, therapists traverse the "change curve" and ultimately experience a professional evolution into an occupation-centered paradigm.

## Comments

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## Keywords

occupation-based practice, occupation, practice barriers, practice change

## Cover Page Footnote

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## Credentials Display

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Occupational therapy is grounded in the belief that occupation is health-promoting and can be used therapeutically to treat individuals, groups, and populations with physical, emotional, and social illness (Meyer, 1922; Reilly, 1962; Wilcock & Hocking, 2015). William Rush Dunton, a founder and early president of the American Occupational Therapy Association (AOTA), identified occupation “as necessary to life as food and drink. Sick minds, sick bodies, sick souls may be healed thru occupation” (Dunton, 1919, p. 10). Occupational therapists share this foundational philosophical belief that engagement in daily occupations powerfully influences health, provides meaning to a person’s life, and empowers autonomy (Blanche & Henny-Kohler, 2000). This idea was best illustrated by Mary Reilly’s Eleanor Clarke Slagle Lecture when she proposed that “man, through the use of his hands as they are energized by mind and will, can influence the state of his own health” (1962, p. 2). This oft-quoted statement exemplifies the essence of occupation-based practice and reveals the causal relationship between engagement in meaningful occupations and the health and well-being of people.

The execution of these philosophical occupational perspectives is facilitated through taxonomies to define and distinguish how occupation is used in practice. Gray (1998) offers a dichotomy of “occupation as ends” and “occupation as means” to differentiate the role of occupation in the plan and delivery of therapeutic services versus occupation targeted as the end goal. Fisher adds to the lexicon to delineate the use of and regard for occupation in the profession, distinguishing between occupation-based and occupation-centered approaches. Occupation-centered refers to a belief, perspective, or organizing framework in which occupation is central to concern and importance (Fisher, 2013). The term occupation-based refers to the active placement of occupation as the primary element of practice using a “person’s engagement in occupation as the method of our evaluations and interventions . . . as the therapeutic agent of change” (Fisher, 2013, p. 164).

These perspectives are not only philosophical but also effective in generating improved outcomes from therapeutic interactions. As synthesized in a systematic review, several studies have empirically demonstrated that participation in occupations has positive health and quality of life outcomes (Stav et al., 2012). Comprehensive systematic reviews similarly identified positive health outcomes when occupation-based interventions are used across populations, including clients with mental illness (D’Amico et al., 2018; Schindler, 2010), those with dementia (Smallfield & Heckenlaible, 2017), children (Arbesman et al., 2013), people recovering from a stroke (Gillen et al., 2014), individuals recovering from a traumatic brain injury (Powell et al., 2016), and clients with acute and chronic hand injuries (Robinson et al., 2016). The evidence demonstrates that meaningful occupations aligned with the client’s interests facilitate better outcomes than engaging in a rote exercise program (Skubik-Peplaski et al., 2014).

While the use of an occupation-based approach is critically important to preserving the contribution that occupational therapy brings to the therapeutic process, the prominence of occupation in occupational therapy practice has wavered during the profession’s 100 years of existence. In the early decades of the profession, therapists implemented occupation as a therapeutic approach. It was consistent with the philosophies of the profession’s founders, who touted the health-promoting qualities of occupation (Christiansen & Haertl, 2019). However, as the health care system evolved throughout the United States and became increasingly dependent on third-party payment, occupational therapists relinquished the occupational core of practice and began using reductionist approaches (Christiansen & Haertl, 2019). Reductionistic approaches primarily focus on the client’s component parts while not addressing the complexities or needs of occupational engagement. For example, reductionistic practice

may target the range of motion and strength of a client's wrist but not address the client's occupational goal of meal preparation for their family. By the 1970s, the trend toward reductionistic practice had evolved into what is recognized as a mechanistic approach (Kielhofner, 1997) or medical model practice (Molineux, 2004; Reed & Peters, 2008). This approach is characterized as discretely different from occupation-based in that it follows an agenda other than health through occupation. Any number of influences may drive the unique agenda of these practices. The source of these influences may be the practice setting, the industry, the therapist, or the client. Practice may be influenced by any of several persuasive authorities, including a medical focus, educational requirement, psychological perspective, business model, military priority, complementary and alternative medicine, or any other compelling authority. Occupational therapy services in the United States primarily fell under the compelling authority of a medical focus resulting in a trend toward medical model practice. Though this transformation toward reductionistic or medical model practice helped validate the profession in the medical community and secured payments for services, it resulted in deviation from the profession's values. The widespread reinforcement from the medical community and third-party payers overshadowed the realization of the constraints of reductionism and the associated loss of recognition of humans as occupational beings (Kielhofner, 1997). By the end of the 20th century, the reductionistic practice patterns and widespread loss of professional identity catalyzed an "occupational renaissance" with renewed attention to occupation in theoretical development, research, and practice (Whiteford et al., 2000).

In light of the disparity between the professional trajectory and recent philosophical transitions toward occupation (Molineux, 2004; Whiteford et al., 2000) and the absence of occupation in practice (Che Daud et al., 2016; Colaianni & Provident, 2010), the researchers sought to study the effect of an occupation-based clinic makeover on client outcomes as well as therapists' perceptions of using occupation in practice. Specifically, the researchers aimed to understand how an occupation-based clinic transformation would impact therapists' attitudes and experiences.

### **Context of the Study**

The occupation-based clinic makeover project applied the therapeutic use of occupation described in Gray (1998) and Fisher (2013). The clinic makeover project was guided by the Ecology of Human Performance (Dunn et al., 1994), which recognizes the influence of context on performance and includes the available resources and the physical and cultural aspects of the environment. This comprehensive, mixed-methods study tested the effectiveness of practice context modification on client outcomes and occupational therapist experiences using occupation as a primary therapeutic approach. The project was grant-funded through an internal college grant that supported the purchase of occupation-based materials. Studies have shown the lack of physical space and funding to purchase occupation-based materials can hinder the infusion of occupation into practice (Che Daud et al., 2016; Colaianni et al., 2015). Supplying a clinic with occupation-based materials was intended to overcome some of these resource barriers. The study was set in a skilled nursing facility known to rely heavily on a medical model and exercise-based approaches based on Student Evaluation of Fieldwork Experience feedback. The facility's client population was older adults receiving rehabilitation services consistent with a skilled nursing facility. The facility is situated in a more extensive health system on a campus that houses an inpatient rehabilitation hospital, independent living apartments, and an assisted living facility. The facility administration and occupational therapy director were invited to participate in the research opportunity and, in exchange, would retain all of the occupation-based materials purchased for the

study. The qualitative study strand aimed to understand occupational therapists' experiences and perspectives of a clinic environmental modification to support occupation-based practice. The quantitative strand of the study compared current client outcomes on the functional outcome measure adopted by the facility against a matched-pairs retrospective cohort selected from medical records from the year before the study. This article only presents the qualitative strand of the mixed-methods study.

The selection of occupation-based kits was conducted with feedback from the participating therapists to reflect meaningful occupations of interest to their clientele with relevance to their demographics. The makeover included clinic preparation by removing exercise-based therapy equipment, such as the arm bike, range of motion arc, resistive putty and bands, and pegs. Because of the presence of equipment shared with physical therapy, some exercise-based equipment, including hand weights and weighted dowels, remained in the clinic; however, the study participants were asked to avoid using exercise-based equipment. The occupation-based kits encompassed a wide array of occupational pursuits. They included home management, pet care, office tasks, cooking, woodworking, painting, coloring, crocheting, female and male grooming, male dressing, leisure, money management, car washing, and seasonal items such as Easter eggs and candy. The researchers also stocked the existing therapy kitchen with fresh and packaged foods and various kitchen supplies, such as pots, pans, utensils, bowls, and dishwashing materials. The therapist participants were provided with a basic orientation to the occupation-based kits, and they used the kits exclusively for 4 months.

### **Method**

This phenomenological study represents the qualitative strand of a mixed-methods study of an occupation-based clinic makeover. Previous phenomenological research exploring therapists' experiences using occupation-based hand therapy (Colaianni et al., 2015) proved insightful. The researchers aimed to glean insight into the therapists' experiences following a clinic environmental modification from reductionistic tools and equipment to occupation-based materials. Phenomenology was the most appropriate approach because of its ability to capture what and how participants experience a phenomenon (Creswell & Poth, 2018; Moustakas, 1994). After approval from the facility and the university institutional review boards, the researchers invited eligible occupational therapists to participate in the study. Individuals who worked full time as occupational therapists and occupational therapy assistants or worked per diem greater than 25 hr per week and were present throughout the quantitative strand of the study qualified to participate. Individuals assigned to administer client evaluations more than 50% of the time or work per diem at other facilities were excluded from the study.

A convenience sample of six occupational therapists initially agreed to participate. Two therapists opted out of the study by moving to a different building situated on the same campus for the duration of the study. One week into the study, a therapist who had been out on vacation expressed interest and agreed to join the study. Two additional therapists who had not participated in the one-on-one interviews expressed interest in sharing their perspectives and were consented before the focus group. Per the provisions in the informed consent form, the participants were permitted to withdraw from the study at any time. The total sample of the study included a mix of nine occupational therapists and occupational therapy assistants, which is consistent with the range of three to 10 participants suggested in phenomenological research (Dukes, 1984). The participants had a range of practice experience from 3 to 34 years, with a mean practice experience of 14.2 years.

## Data Collection Materials

The large research team of 18 members was divided, half dedicated to the quantitative strand and the other half assigned to the qualitative strand. Following a comprehensive review of the literature focused on the historical and philosophical trajectory of occupation as a core of occupational therapy, occupation-based practice, and the barriers to using occupation in practice, the qualitative team developed a semi-structured interview and focus group discussion guide. The interview schedule questions (see Appendix A) initially gathered demographic information about each participant specific to educational background and work experience. Questions about the therapists' views and understanding of occupation and occupation-based practice were grounded in the work of Meyer (1922), Reilly (1962), Fisher (2013), Wilcock and Hocking (2015), and Gray (1998) to get a sense of their philosophical alignment with the profession's foundational principles. To discover how their delivery of services aligned with occupational philosophies, the interview inquired about typical practice both before and during the occupation-based clinic makeover and perspectives on the use of occupation-based materials and client outcomes. The remaining interview questions were generated based on the Ecology of Human Performance constructs. The questions focused on the therapist as a person, the practice environment and resources as the context, practice inclusive of clinical and documentation activities as the tasks, and the interrelationship between the aforementioned. The discussion guide (see Appendix B) used during the focus group was generated based on the initial review of the literature and questions that arose from the interview exchanges with the participants. The facilitated conversation during the focus group aimed to understand experiences with occupation-based practice and the encountered barriers (Che Daud et al., 2016; Colaianni et al., 2015) and their perspectives of professional transformation throughout (Whiteford, 2020; Whiteford et al., 2020). Both the interview schedule and discussion guide were reviewed for content, clarity, and structure by the quantitative team.

## Procedures

Following approval by the Nova Southeastern University Institutional Review Board for adherence to ethical standards for human subjects, the study began by transitioning the clinic from therapy equipment and materials to occupation-based materials along with an orientation to the equipment organization and location of storage. The orientation was intentionally limited to allow the participants to freely experience the new materials and to minimize bias imposed by the researchers. All occupational therapists were exposed to the new materials regardless of participation in the study since it was the facility's administrative decision to transition occupational therapy services toward occupation use. Following a 2-week acclimation period to become familiar with the occupation-based materials, the occupational therapists who agreed to participate in the study completed the informed consent process before data collection. Before administering interviews, each researcher conducted mock interviews with members of the quantitative team to ensure fluidity, exclusion of bias, and practice observing body language, and to rehearse generating and asking follow-up questions. The interviews with the individual therapists and groups of two researchers used the semi-structured interview schedule. The pairs of researchers ensured proper operation of the recording device, documented noteworthy points in the interviews, and collaboratively asked follow-up questions as indicated. The individual interviews ranged in length from 30 to 45 min. The study participants continued to use the occupation-based materials for 4 months during data collection of the mixed-methods study's quantitative strand. In the fourth month of occupation-based material use, the researchers conducted a focus group lasting 2 hr, using the discussion guide to obtain additional perspectives and experiences after more prolonged use of occupation in

practice. The researchers recorded all interviews and the focus group on digital voice recorders to preserve the integrity of the study participants' words, tone, and sentence structure. Each interview and the focus group were transcribed verbatim by the researchers to ensure the participants' statements' accuracy. The concurrent timing of the interviews and initial coding allowed for awareness of the point of data saturation when no additional interviews were conducted.

### **Analysis**

Data analysis followed the heuristic process in phenomenological analysis suggested by Moustakas (1994). This process included immersion (Kenny, 2012) when the researchers placed themselves in the context of the experience with regular visits to the site for the official purpose of collecting quantitative data and included some observation of practice. The researchers preserved a space for incubation (Kenny, 2012). During weekly team meetings, the researchers shared insights and began to build understanding. Illumination (Kenny, 2012) occurred throughout the data collection and analysis phases, thus facilitating the researchers' knowledge of the therapists' experiences as the data evolved from codes to categories and into themes. Reflection on the data, researchers' identified biases, and individual and collective notes served as explication (Kenny, 2012), producing further clarity. Finally, the researchers engaged in a creative synthesis (Kenny, 2012) of all of the information from the entire process to generate a comprehensive understanding of the participants' experiences.

Data, which were all deidentified during data collection as the participants selected pseudonyms, were maintained in a password-protected folder in the cloud only accessible to members of the research team. Transcripts were initially read and preliminarily coded by each researcher individually using a web-based qualitative data management program, QDA Miner Lite (Provalis Research, 2016). The researchers reviewed each transcript in search of salient text depicting the therapists' positive and negative clinical and professional perceptions of using an occupation-based practice approach as well as specific experiences using the occupation-based materials. The researchers convened to compare codes until consensus was reached, at which time they merged the electronic codebooks. The researchers finalized coding, then collaborated and combined similar codes into categories depicting the experience of change, challenges of occupation-based practice, the change process, and exemplary occupation-based practice. Further reflection with the data revealed a temporality to the data that emerged as a transition and professional growth process. All study transcripts, coding, themes, and notes will be maintained for 36 months from the conclusion of the study.

The researchers established study rigor through several components of trustworthiness to ensure credibility, transferability, dependability, and confirmability (Law & MacDermid, 2014). Members of the research team sought credibility by collecting data over a long period, from a range of participants, and using a variety of data collection methods. The use of triangulation contributed to the credibility through multiple participants, numerous researchers, and multiple data sources. While this and other qualitative research intend not to generalize, transferability was established through a description of the practice setting, professional experience, and the conditions of the clinic makeover project allowing for comparison to other practice settings. The research team secured dependability of the findings while the researchers were intentional in their progression from data to codes, through categories, and into emergent themes. Finally, the rigor of the study was reinforced with confirmability through the collaboration of the research team from the design through execution and analysis phases of the study, ensuring the neutrality of the data and preventing bias from any single perspective.

### **Results**

The findings from this qualitative study include the following two themes: (a) challenges to occupation-based practice and (b) occupation-based metamorphosis. The themes depicted the current struggles faced by the study participants and the professional growth and change that transpired as they grew into occupation-based therapists.

### **Challenges to Occupation-Based Practice**

The participating occupational therapists were anxious and resistant to changing their habituated practice patterns to use occupation-based approaches. Compounding the therapists' apprehensions were the many challenges that would impede their transition toward occupation. The challenges were both personal and contextual. Initially, the therapists had varying degrees of emphasis on occupation in their professional training. They were not conscious of their beliefs and understanding about occupation or the use of occupation in practice. The contextual challenges included a pervasive exercise culture, client expectations of exercise, logistical obstacles associated with documentation and billable time, and the physical space and equipment shared with physical therapy.

The participants candidly acknowledged their apprehensions about the shift toward occupation-based practice, which were summarized when one therapist shared her feelings as, "Honestly, shock, anxiety. A little apprehensive. It's going back to the foundation of occupational therapy, so it's kind of switching gears, and the anxiety was pretty high." Several of the participants shared this particular sentiment in their expressions of "to be honest with you, the anxiety was pretty high" and "outside of the anxiety of having to change things." One therapist admitted her anxiety was related to the "stresses of not having what you wanted to do."

The therapists acknowledged not only their anxiety, but also their opposition to changing their approach to practice. One participant succumbed to his resistance and admitted that "going next door [to the sister facility] is easier because it was not so challenging to come up with something different. Going next door seemed to be a little breezier, than being here, less thinking, less analysis." Conversely, another therapist ultimately recognized the benefit of expanding her practice when she shared, "I was resistive at first, and I think it's going to be good, and I think it's going to open up areas that may not have been."

The participants' anxiety and resistance were grounded in the challenges they faced in providing occupation-based services. Their views, beliefs, and understanding of the value and use of occupation inhibited practice. When asked about the distribution of occupation versus exercise therapeutic approaches at the beginning of the study, one participant nervously chuckled as she responded, "therapeutic exercises, I would say maybe 75% of the treatment session." The firmly held beliefs in exercise seemed to limit their acceptance of occupation as an effective and powerful therapeutic medium. One occupational therapist touted his credentials as the rationale for not using occupation when he said, "Me personally, I have certifications in personal training, rehab fitness, geriatric fitness, strength, and conditioning in geriatrics, so my background is with exercise." The reliance on, and pride in, exercise-based credentials shaped these therapists' practice decisions. A participant explained,

I am all about function and ADLs, I do believe in strengthening, I am certified, I just got certified in Tai Chi, I'm Kinesio Taping® certified, I have taken many fall prevention courses, so I feel that strengthening is important in the respect of balance, so I do use ther-ex.

The high regard for exercise and the universal need to address strengthening for all clients was a widely held belief. The participants shared their feeling of loss after the transition to occupation-based approaches saying, “I certainly do miss the opportunity to do strengthening” and described the insufficiency of occupation-based strengthening approaches. Another participant expressed an inadequate feeling when she described her efforts as, “I have definitely done several different approaches in several different manners, as far as opening heavy doors, bringing the cans down, but still not getting the strengthening, building that I’m looking for.” One therapist seemed to recognize her high regard for exercise was not aligned with the profession’s beliefs and went so far as to apologize when she said, “It opened me up a little more. But my field of interest is still the exercise and weights, sorry.” One therapist’s allegiance to exercise made her feel less effective as a therapist when she focused on occupation. She explained,

There have been patients that have left here, where I’ve literally thought to myself, you know what? If I was able to do this with them for a few days and stuff, with some more resistive stuff, I think they would have been better off. And in that regard, it’s not a good feeling.

The occupational therapists demonstrated that they recognized their habituated use of exercise as well as the need to be aware of their therapeutic choices when summarizing practice by saying, “well, because we’re not doing any exercises, we had to get really, really creative with some of the patients.” Some of the participants did not adopt the concept of occupation as defined by the profession to be inclusive of meaning the engaged person. One example of this gap was highlighted when a therapist described an interaction with a client and subsequent selection of a therapeutic activity. The therapist recounted the exchange: [the client said], “‘I’m into fixing cars.’ If we mention anything about crayons or woodwork, he would do it as an activity, but not because he’s so interested in it. So, we had him sweep the floors and get in the kitchen.”

A final, personal challenge expressed by the participants was their existing habituated practice patterns and established shortcuts. The habits and efficiencies of exercise-based practice make for a more straightforward workday, as one participant articulated: “To be honest with you, it would just be easier, actually, to set your patient up on a restorator or a therapeutic exercise and document, especially with the electronic documentation that we are doing now at the hospital.”

More general and pervasive were the contextual challenges, which served as barriers to using occupation in practice. One of those challenges was the expectation of exercise by the clients. One participant recounted an exchange with a client when she only wanted to exercise to lose weight and refuted the goal of independence because she had family around to help her.

Occupational therapists who were making a concerted effort to transition to occupation found the common expectation of exercise more complex and, at times, frustrating to manage. One participant shared an interaction when a client said, “‘okay, when I come back downstairs, I want to do some exercise.’ And I was like, okay, please don’t be on my schedule next time.”

The therapists noted other logistical barriers to using occupation-based approaches specific to the planning and documentation of services. One participant explained the struggle expressed by several therapists when she described the use occupations as “more strenuous, maybe a little more stressful . . . because, again, she had to get out of that routine and go to a new routine or find a new way of doing things.” The additional planning to select the best intervention proved to be a hurdle “because there are

new things, you know, it's time-consuming." In particular, therapy services offered outside of the rehabilitation gym were more problematic as it "was a challenge, trying to find something where I can bring to the room and work with him." Once the occupation-based interventions were implemented, recording the therapy session also required a shift in approach, as one participant shared: "My documentation has changed significantly." These challenges collectively served as obstacles to the adjustment to a new method of occupational therapy practice.

### **Occupation-Based Metamorphosis**

The study participants shared their initial apprehension toward a shift to occupation-based practice. Still, they experienced professional transformations as they became reacquainted with the core constructs of occupational therapy practice and emerged as occupation-based therapists. Their personal and professional growth included a reconnection to the meaning of occupation and the ability to select occupations for the just-right challenge intentionally. The therapists refreshed foundational skills, such as activity analysis, critical thinking, time management, and documenting occupation as a therapeutic medium. As the therapists engaged in occupational exploration with clients, they began seeing the clients not just as a diagnosis but as individual people with unique needs. The therapists recognized the increased benefit to clients as they became more occupation-centered in their thinking, resulting in stronger connections and rapport with clients. Overall, their attitudes toward occupation and the outcomes produced by this approach were positive, with renewed value for occupation.

Throughout the study, the occupational therapists had the opportunity to become reacquainted with the core of the profession, the full scope of practice, and treating the whole person. The infusion of occupation into the therapy gym sparked conversations and new perspectives. One participant explained the start of their professional growth as,

We have been talking about how we can incorporate maybe different scales we can use, how can we measure it. And I think doing this process has helped me to think of some ways perhaps we can introduce as a department, ways to focus on more of the cognitive aspects as well as the physical aspects, and also the psychosocial ramifications. Because when that person gets that project done, even if they are not taking it home, if they did something they have done before or they have that sense of accomplishment because they made an omelet, you know, or they set the table.

As clients engaged more in occupation during therapy, the therapists began to reflect on their purpose as therapists. One of the therapists described, "There was one lady who just was showing us how to fold napkins in a special way and setting that table. Even in that reminiscing, that psychosocial, cognitive aspects of OT have gotten lost, I think, over the years."

Immersion into occupation-based practice triggered memories of their professional training and how to implement those forgotten skills. A participant described the recall of professional knowledge by saying, "if I want to do standing tolerance, wow, there are all these ways I could incorporate this into that. So maybe some emphasis back on our training in activity analysis."

The process of professional growth was a collective experience among the participants that seemed to facilitate the professional evolution as one participant described her thought process when she said,

Wait a minute; I can't pick up those weights. What is it that you expect me to do? How am I going to do this? Watching everybody work through that process, it was fascinating watching how everybody adapted, and learned, and kind of put it together.

An area of notable growth among the participants was the appreciation for the meaning of occupation to the client. The therapists expressed a realization for the power of meaning derived from the activity, which was "centered around things that they enjoyed" and improved performance. A participant recalled an experience during which a client derived a lot of meaning from occupational engagement. The therapist said,

We took her into the kitchen and convinced her to make an omelet. She was a little anxious about the process; she hadn't done this in years. But she was the type of person where she was the homemaker; she had kids, the husband was out, in her day, working, she would socialize a lot. She came from a big family. Once she was in the kitchen, everything just became automatic, and she was so excited to crack the egg, put the egg in the pan, place it on the stove; when she was done, she was able to cut the omelet in half and serve it. She was so excited toward the session, she mentioned that she wished we had videotaped to send it to her family because her family wouldn't believe that she made an omelet. We were so excited. How often do you get to say a 99-year-old makes an omelet for you? It just kind of brought her back to what she used to do as far as entertaining and socializing, so again it built her confidence and was like, "hey, I was able to do this."

Another therapist recounted a similar experience of a client demonstrating enhanced performance while engaging in meaningful occupation when she explained,

The day before, he was talking about the Bible and quoting, so I [said] give me an inspirational quote or tell me something that'll help motivate you to going home. He gave me the quote, and I looked it up on the computer. I was able to pull out an image with the quote with different colors with different fonts, brought the canvas out, and he was like "wow" and it was so interesting how he looked at the quote, he did his own variation of the quote, but he was able to problem-solve. He cut the paper that I printed the quote, and I folded it to fit to put it on the easel, and he used it as like a guide to do the stenciling. You could see how he kinda brightened up, you could see he felt a little more optimistic about going home, and I said, "yeah, you could put this on your door or in your room or whatever and just remember your progress."

Other occupational therapists shared similar stories, including the selection of a money management activity for a client who had been a certified public accountant, use of a grooming kit to allow a client who was particular about her nails to reapply her nail polish, and creation of craft and wooden projects to give as gifts to loved ones. Each example involved the intentional selection of a therapeutic occupation that was meaningful to the client.

The transition to exclusive occupation-based approaches also sparked the reconnection to foundational practice skills, such as activity analysis, critical thinking, time management, and documentation. One participant reflected on a skill she learned while training to be an occupational therapist. She said,

The activity analysis is what the school that I attended focused on heavily [and] is now being put to use. It is an activity, home management, IADL, whatever; it is now being put into use.

Whereas before, under the biomechanical, fine, but I am relearning and seeing the difference.

A therapist explained how her view of her clients expanded after reconnecting with the concept of occupational analysis as she explained, “You know, using activity analysis, being able to break it down, so you’re challenging cognition as well as coordination . . . sequencing, fine motor . . . [and] range of motion. So, you have to make a plan and then execute that plan.”

The therapists collectively experienced a professional evolution through self-initiated group activities, including in-services about crafting and documentation, the introduction of assessment tools, such as an interest checklist, and the creation of an occupational analysis matrix cross-listing therapeutic activity options. The occupational therapy director conveyed their combined work as she described how they

started to develop a functional activity analysis, just going through all of them, for example, my headers are range of motion, gross motor, fine motor, grasp, all the way up through perception, spatial awareness, social interaction, all of those different things we might be cueing in on with a patient, those activities we found ourselves, we found the most commonly done ones.

Another area of development during the metamorphosis into occupation-based therapists was their facilitation of occupational exploration with clients. The ability to engage in occupational exploration as a therapeutic process connotes a level of regard for the client as an occupational being and comfort, flexibility, and aptitude in critical thinking and occupational analysis. One participant shared this discovery process begins when the therapeutic process starts as she stated, “now upon eval, we are doing a very small occupational profile type of thing just getting their likes, their hobbies, things like that so that we can have an idea of what to start with.” The clients expressed an appreciation for the opportunity to explore occupations, and a therapist recalled the process for one of her clients, saying, “they kind of rediscovered interests, things that they used to do in the past. Some of them discovered skills, some of them would paint freehand, and they’d say you know they hadn’t done it in years.” Another therapist relayed an encounter with a client when he conducted the evaluation and “was asking him questions about what did he do for a living and what hobbies. He was like, ‘Oh, this is good you’re asking me questions about myself.’”

Also, the therapists became more invested in the clients as they built stronger connections and established rapport. A participant explained the relationship building as

I think you definitely form more of a rapport with them. I think their respect grows for you, knowing that you want to find out a little bit more about them. You’re not just gonna sit them down at the table to give them something to do to pass the time. You’re figuring out their likes, their interests, and I think that helped a lot. And things that they enjoy, it kind of forms a conversation, “oh, how do you do that?” And I learn from them, and they learn from us, so I think it helps that way.

The inclusion of meaningful occupation in practice led the therapists to view their clients differently, as people and as occupational beings rather than the diagnostic label assigned at admission. One therapist explained the shift in her perspective when she admitted, “now my interview’s a little bit more in-depth, and I know the patient, I don’t know them as a diagnosis or the room number or x, y, and

z.” Another therapist corroborated this sentiment as she described her shift in thinking when she said, “you see the patient, as a person, as okay, this was their prior, this isn’t just who you know in therapy, but sometimes we have the habit when we refer to patients as room 216 or 211.” The intention of therapeutic care also changed as the clients were humanized, and the therapists asked themselves, “how am I going to get this person where this person needs to be in a very personal way?” This new angle on viewing clients as whole people began to infiltrate other members of the team. One of the participants relayed a story about how others recognized a client as she described,

I heard the transporters talking, and they were talking amongst each other, they were like, “oh, did you know mister so and so? He was an accountant, and he’s doing the money management.” So, you know the patient is a person, and that’s how I see that it’s changed my relationship with the patient.

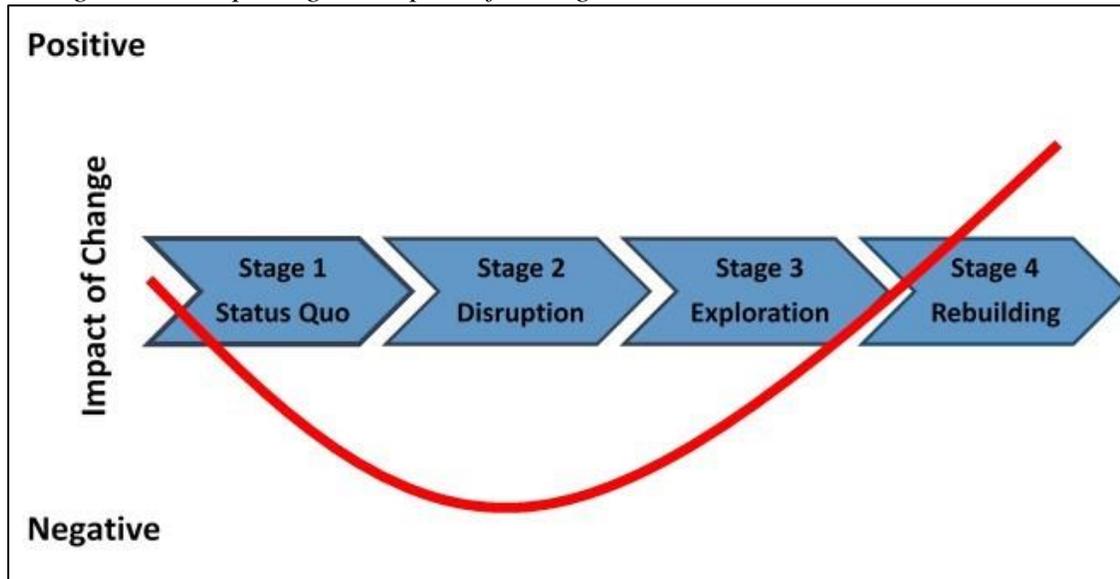
After the conclusion of the study, the rehabilitation director restored access to the exercise equipment. The researchers asked the participants about their practice moving forward specific to the mix of occupation-based and exercise-based approaches. The therapists reported they would continue to use the occupation-based materials with one planning on a 75% occupation to 25% exercise ratio. Overall, the participants recognized the benefits of infusing occupation into practice and acknowledged the previous pattern of service delivery, as one described the evolved approach as “getting to know them a little bit better, figuring out what they actually like and catering to their interests versus what is easiest for us to give to them.”

### **Discussion**

Consistent with the literature, the participants experienced a range of barriers to infusing occupation into practice. Che Daud and colleagues (2016), Colaianni and Provident (2010), and Whiteford and collaborators (2020) found similar obstacles to implementing occupation-based practice reflecting both professional and contextual barriers. The project’s efforts to reduce some of the obstacles seemed to be successful, as evidenced by the participants’ professional journey.

The process of professional growth and change among occupational therapists is less represented in the literature. Still, the experiences of enhanced professional satisfaction, reconnecting with their professional roots, and transforming as therapists were similar to the growth that transpired among a group of therapists in a forensic mental health setting (Whiteford et al., 2020). The theme that emerged from the participants’ experiences represents the trajectory of the change process from challenges and resistance by integrating an evolved approach to occupational therapy service provision. Similarly, the process of professional growth as experienced through practice-based inquiry has been compared to “pregnancy and parenting – you start with a small seed that grows, you get sick and then better; then you birth it, and it’s great, but at times it exhausts you” (Whiteford, 2020, p. 7). This process of change and professional growth paralleled the sequence of organizational change known as the change curve. The change curve exists in the organizational literature in several different iterations, but all are grounded in Kubler-Ross’ (1969) stages of grief. The therapists individually and collectively progressed through four stages of the change curve. Figure 1 illustrates the stages of the change curve as experienced by the participants.

**Figure 1**  
*Change Curve Depicting the Impact of Change on Practice*



At the start of the study, the participants were in the first stage, Status Quo, which includes feelings of shock and denial as a change in the status quo challenged them. This stage occurred when the study was introduced to the participants and they became aware that their existing patterns of practice would change. Evidence of the first stage was apparent as some therapists opted to move to the sister facility for the duration of the study. The participants entered Stage 2 of the change curve, Disruption, once the inevitability of the clinic change was realized, which includes adverse reactions; resistance; and feelings of anger, protest, and fear of the consequences of change. The effect of change during the second stage is often negative as individuals are resistant and have not acclimated to new procedures and materials or established competency and routines. During this stage, the participants defended their existing practice, stating they were already function-based and would not benefit from introducing the occupation-based kits. The participants expressed feelings of fear about providing occupational therapy services effectively in the absence of exercise-based equipment, apprehension because of a lack of proficiency with the occupation-based materials, and uncertainty about how to document their services. Risk during the second stage includes the possibility of organizational disruption if the change is not carefully managed. However, during the study, the occupational therapy director effectively managed the change to avoid the potential chaos by providing training and in-services to the therapists and guidance specific to the documentation of occupation-based approaches. The expectation of this leadership role was not integrated into the study design and was merely an example of effective leadership and strong management of the human capital in the department. Eventually, the therapists entered Stage 3 of the change curve, Exploration, when their focus shifted from loss to the acceptance of the change. This stage includes testing and exploration while assessing both the positive and negative aspects of the change and learning how to adapt. During this stage, the participants engaged in trial and error and ultimately determined the best approaches to yield positive therapeutic results. Also, during this time, the therapists weighed the difficulties of providing occupation-based services against the

positive relationships with and satisfaction of the clients. The impact of change during the third stage begins to improve as individuals begin to accept the change, develop familiarity with new processes, and establish patterns of functioning. During the final stage, Rebuilding, the participants accepted and embraced the practice change as they formulated new ways of working with clients. During this final stage, the impact of the change exceeds the starting point, and there is recognition of the positivity associated with the change. After four full months of exclusive occupation-based practice, the participants had embraced the change and committed to shifting the concentration of their practice approaches to occupation-based even when the exercise-based approaches were once again available to them.

The perspectives of the occupational therapists versus occupational therapy assistants were intentionally omitted because the study focused on the selection and use of occupation-based materials for intervention. This aspect of practice is inherently similar across both levels of providers and would likely yield the same experiences. As anticipated, when the data sources were analyzed collectively, similar codes were found across all interviews and the focus group regardless of the participants' professional level of practice.

### **Implications for Practice**

The findings of this study highlight the distinct value of occupation-based practice in distinguishing occupational therapy from other disciplines. This study also revealed the numerous personal and contextual challenges associated with incorporating occupation into practice. An analysis of the department's culture specific to alignment with occupation-centered practice and willingness to adopt an occupational focus is a recommended preliminary step to implement practice change. Cultural considerations are important because a shift to occupation-based practice looks different and uses a different philosophical paradigm. Occupation-based practice generates enhanced client outcomes as described in the literature. It also contributes to reduced duplication of services that may yield more favorable third-party reimbursement. The execution of occupation-based practice can be facilitated with the addition of occupational materials; however, practice change is a complex process. A change in practice requires strong leadership and direction to support the change and help therapists overcome challenges. The role of a guiding entity is consistent with the implementation science literature, which recognizes the importance of mentoring and coaching to facilitate practice change (Manzi et al., 2017). Additional managerial support is necessary to advocate for budgetary support for the initial investment in occupation-based materials and sustained funding to purchase consumable products. In addition to changing therapy tools, the introduction of occupation-based assessments, such as an occupational profile, an interest checklist, or the Canadian Occupational Performance Measure (Law & Canadian Association of Occupational Therapists, 1991) can establish a connection to the client's occupations and personal meaning, thus shaping the direction for an occupation-centered therapeutic process. Therapists who establish an occupational focus for the trajectory of occupational therapy services will notice stronger therapist-client relationships with greater rapport and, ultimately, improved client motivation.

### **Limitations**

Although this research study was carefully designed, some limitations were identified, which may have influenced the findings. The study design intentionally did not include training in the selection, use, and documentation of the occupation-based kits to prevent the participants' bias in the acceptance and use of the materials. The absence of training to acclimate the participants may have inadvertently introduced additional barriers to incorporating occupation into practice. There was a

relatively short period between introducing the occupation-based kits and the start of data collection of therapists' perspectives. Researchers attempted to mitigate this limitation by conducting the focus group at the end of the study to allow the participants to formulate deeper views after using the occupation-based materials over 4 months.

In addition, the researchers observed therapist practice only periodically during weekly visits to the site to collect client outcome data for the quantitative strand of the study. These visits did not represent participant observation as a data collection method that may have yielded additional perspectives. Finally, the lack of a longitudinal perspective prevented the researchers from understanding the participants' professional growth following the return of exercise equipment.

## Conclusion

Occupational therapy is founded on the idea that occupation is health-promoting and supported in the evidence, yet this approach is not widely adopted in practice. For occupational therapy to remain true to its professional identity, practice must remain grounded in its philosophical roots. While authentic occupational therapy practice grounded in occupation is ideal, several barriers to using occupation in practice are well reported in the literature and reinforced by the findings of this study. These challenges confound the supposed resistance to change, making a transition to occupation-based practice seem arduous. A transition to occupation-based practice is admittedly difficult, but a supportive environment with mentoring and effective leadership can facilitate the change. Ultimately, any change initially yields a negative impact; however, the transition can eventually deliver positive results once individuals and the organization have traversed all stages of the change curve.

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## **Appendix A**

### **Semi-Structured Interview Schedule**

1. Are you an OTA or an OT?
2. What is your highest degree earned: Associates, Bachelors, Masters, DrOT, or PhD?
3. Which university did you receive your degree from?
4. Where is this university located?
5. How many years have you been practicing the profession of occupational therapy?
6. On a scale of 1 to 10 of occupation-based practice, with 10 being completely occupation-based and 1 being completely medical model, how would you rate yourself and why?
7. Prior to the study, what did a typical day look like for you as a therapist?
8. How did your typical day change while using occupation in practice?
9. How did you use the equipment provided to you?
10. How did you use the new equipment and materials to treat clients?
11. How did the use of occupation-based materials impact your experience working with your clients?
12. How do you think occupation-based therapy influences the care and outcomes of your clients?
13. Describe the struggles you faced while using strictly occupation-based interventions?
14. How did the use of occupation-based interventions influence your documentation?
15. Do you have anything else you would like to share with the researchers about this experience?

## **Appendix B**

### **Focus Group Discussion Guide**

1. Did anything profound happen with your clients?
2. Are there any specific experiences that you would like to share?
3. Did you notice a change regarding your relationships with the clients?
4. How did you notice that your day changed while using occupation in practice?
5. What did you like the best about using occupation in practice?
6. What did you like the least about using occupation in practice?
7. Is there anything else you would like to share about your experience?