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The professional expertise of community-practicing occupational therapists

Ruth Ramsey

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THE PROFESSIONAL EXPERTISE OF COMMUNITY-PRACTICING OCCUPATIONAL THERAPISTS

A Dissertation Presented
to
The Faculty of the School of Education
Department of Learning and Instruction

In Partial Fulfillment
of the Requirements for the Degree
Doctor of Education

by
Ruth Ramsey
San Francisco
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This dissertation, written under the direction of the candidate’s dissertation committee and approved by the members of the committee, has been presented to and accepted by the Faculty of the School of Education in partial fulfillment of the requirements for the degree of doctor of education. The content and research methodologies presented in this work represent the work of the candidate alone.

Candidate

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CHAPTER ONE
INTRODUCTION TO THE STUDY

Statement of the Problem

Health care is changing in America and around the world. Many of today’s major health issues are community-based issues, such as improving mental health, preventing childhood obesity, managing chronic conditions, and caring for older adults (Institute for the Future [ICF], 2003). Creating healthy, accessible communities helps people lead healthier lives and reduces health care costs. For these critical reasons, health care providers need to learn and use community-based wellness, prevention, and health-promotion strategies. Several critical factors are driving the move to community-based care.

First, costs for health care in the United States are increasing rapidly, at a rate of 6-9% per year. In 2002, total health care costs were over $1.5 billion, representing 15% of the gross domestic product (ICF, 2003). Rising health care costs are creating challenges for individuals who struggle to meet their health care needs and for companies that struggle to remain competitive in a global economy (Employment Policy Foundation, 2005). Community health care that focuses on keeping people well is more affordable than institutional health care provided to people after they become ill.

Second, the population of the United States is growing older and living longer. Persons 65 years of age and older are the fastest growing segment of the population (ICF, 2003). By the year 2030, the number of adults age 65 and older will reach 71.5 million. Older people use two to three times more health services than younger people
use, have more health-related disabilities, and need more support to remain independent in their homes and out of institutional care (United States Department of Health and Human Services [USDHHS], 2004).

Finally, legislation and public policy support the rights of older persons and persons with disabilities to full inclusion in the community. In the United States, this includes laws such as the Americans With Disabilities Act (1990) and the Individuals With Disabilities Education Act (1975). Internationally, the World Health Organization (WHO) focuses on keeping people healthy so that they may experience success as students, parents, workers, and community members. Community-based treatment, prevention, and health promotion are optimal approaches to providing health care for all in a time of shrinking resources and increasing demand (WHO, 2001; ICF, 2003). As a result, health care providers of the future will need to possess significant professional expertise in the provision of community-based services (Dassler, 1984; Grady, 1995; Loukas, 2000; Pew Health Commissions, 1991).

Occupational therapists are licensed health care providers who work with persons having chronic and disabling conditions (American Occupational Therapy Association [AOTA], 2002). Occupational therapy, as a profession, promotes optimal independence and community function for all, regardless of ability or disability level. Occupational therapy leaders have envisioned a future in which health care is community-based and uses wellness and health-promotion strategies (AOTA, 2005). Although occupational therapists should be practicing in community-based settings, the majority of occupational therapists practice in institutional settings such as hospitals, following the biomedical model of practice. Only 6% of all occupational
therapists identify their practice setting as community-based (AOTA, 2005). Very little research has been conducted to study the practice of occupational therapy in community settings or the professional expertise of community-practicing occupational therapists. Therefore, the study was undertaken to examine the professional expertise of occupational therapists in community practice, using a qualitative, phenomenological approach.

Professional expertise is the ability to perform professional tasks and functions at a consistently high level of quality and effectiveness. Current theories of professional expertise generally agree that it is a sequential, stage-specific process developed over time (Benner, 1984). According to Benner, professionals transition from novice to expert levels with the help of peer support and structured learning experiences. Because professional expertise is often domain-specific, expertise gained in one setting may not translate effectively to another setting.

Professional expertise consists of three types of knowledge, blended into a skillful whole to resolve practice problems. These three types of knowledge are formal knowledge, practical knowledge, and reflective knowledge (Tynjälä, 1999). Formal knowledge is theory-based and gained in formal educational settings. Practical knowledge is skill-based, situated learning gained over time and with experience. Reflective knowledge is gained as professionals thoughtfully consider past and future actions and use metacognitive strategies to improve their decision-making processes (Schön, 1983; Tynjälä, 1999).

Clinical reasoning is a critical element of professional expertise in occupational therapy practice. It involves deliberation about the appropriate action for
the clinician to take with a particular patient at a particular time, and requires the integration of formal, practical, and reflective knowledge (Mattingly & Fleming, 1994). Occupational therapy is, by nature, a complex practice, involving calculating and recalculating the course of treatment and factoring in client needs and wishes along with technical and procedural aspects of care. Clinical reasoning in occupational therapy is thereby a complex process, involving both therapist and client actively working together to identify and resolve problems and improve client function.

Current theories about how occupational therapists and other health professionals develop expertise have largely been developed in institutional settings such as hospitals (Benner, 1984; Mattingly & Fleming, 1994). Because community-based occupational therapy practice differs significantly from institutionally based practice, current theories of professional expertise may not apply to these settings. For example, novice occupational therapists may find themselves in community-practice settings without access to the kinds of supports that help them develop professional expertise, including formal learning opportunities and structured mentoring. Occupational therapists who have achieved expert levels of practice in institutional settings may revert to novice levels of expertise after they transition to community practice.

Community-based occupational therapy practice differs from institutionally based occupational therapy practice in several important ways. Institutional practice typically uses the biomedical model of individual diagnosis and treatment while community practice uses the social rehabilitation model of rehabilitation and support
for independent living (Scaffa, 2001). Community health care funding does not typically come from third-party reimbursement such as medical insurance. A variety of services are often provided in community settings, such as vocational, social, and housing support services, which fall outside of a strict medical-necessity standard for treatment as applied in hospitals.

Occupational therapists in hospital settings operate as clinical specialists within a hierarchical organizational structure, with well-defined job responsibilities and lines of authority, while occupational therapists in community settings operate as generalists within a more egalitarian, decentralized organizational structure (Dougherty, 1994). Occupational therapists in community settings often function autonomously, exercising independent professional judgment regarding optimal treatment rather than only following physicians’ orders.

Occupational therapists in hospital settings typically treat the individual patient, while in community settings they may also work with family members, modify home environments, or provide group interventions. In hospitals, service recipients are referred to as patients and health care providers are viewed as experts with ultimate authority over treatment decisions. In community practice, service recipients are referred to as clients or consumers, and make decisions about their care in a collaborative process with providers (McColl, 1998).

Because of the differences between institutional and community occupational therapy practice, different types of professional expertise may be needed by occupational therapists in community practice. However, little research has been conducted in this area. It is not known how community-practicing occupational
therapists develop professional expertise. It is not known in what proportion community-practicing occupational therapists use formal, practical, and reflective knowledge to develop and maintain expertise. It is not known whether current academic preparation is sufficient to prepare occupational therapists for community practice, or whether opportunities for professional development are sufficiently available for community-practicing occupational therapists (Lemorie & Paul, 2001). Little is known about the frequency and types of clinical reasoning used by community-practicing occupational therapists.

Therefore, a study of the professional expertise of community-practicing occupational therapists was conducted, using a qualitative, phenomenological research design. Phenomenology is both a philosophy and a research method, and has its roots in the perspectives of Husserl, Heidegger, and Sartre (Moustakas, 1994). Phenomenological approaches value the individual voice of each person and assume that individual experiences and perspectives are worthy of study and understanding. Phenomenological research explores the meaning of the lived experiences for individuals about a concept or phenomenon (Van Mannen, 1990).

According to Wilding and Whiteford (2005), phenomenology is an appropriate approach to the study of occupation, which is a key concept of occupational therapy. Occupation is defined by occupational therapists as activities of everyday life, named and given meaning by the individual (AOTA, 2002). Both occupational therapists and phenomenologists are interested in the subjective experience of the individual. Phenomenologists and occupational therapists both use a holistic approach to understand the individual in his or her environment, and both
hold humanistic beliefs about the inherent worth of each individual. Many researchers have used phenomenological methods to study the experiences of health and health care for individuals (Padilla, 2003; Rosa & Hasselkus, 2005; Ward, 1996; Ward, 2003). These researchers believe that health, illness, and health care are multidimensional constructs, and that exploration of the health and illness experiences of health care providers and patients yields valuable insights into those phenomena. Using a phenomenological approach for the current study enabled me as the researcher to explore the meaning of professional expertise to the participants and to hear their first-hand accounts of their experiences in community practice.

Purpose of Study

The purpose of this study was to examine the professional expertise in community-practicing occupational therapists, using a qualitative phenomenological method and approach. Community-practicing occupational therapists were recruited for the study from a range of practice areas and with varying amounts of experience.

The study sought to answer the following broad questions: What is professional expertise in community-practicing occupational therapists? Which types of knowledge that comprise professional expertise are more or less important to the success of community-practicing occupational therapists? What types of clinical reasoning approaches are used most prevalently by community-practicing occupational therapists? What factors are perceived by community-practicing occupational therapists as facilitating or inhibiting their professional expertise?
Significance of Study

The study has significance for community-based occupational therapy practice and education, for a variety of reasons. First, growing numbers of occupational therapists will be practicing in community settings in the future (AOTA, 2005). The study provides a better understanding of what constitutes professional expertise in community practice and how occupational therapists develop expertise in community practice, which may help support the growth of the profession and success of these practitioners.

Second, the study provides a better understanding of the process by which community-practicing occupational therapists develop professional expertise, which may assist occupational therapy educators to design appropriate educational experiences and fieldwork placements for community practice (Rosa & Hasselkus, 2005). Educational and fieldwork experiences typically have a significant influence on how and where therapists choose to practice (Lewicki, Smith, Cash, Madigan, & Simons, 1999).

Third, the study provides information that may be useful for supervisors of occupational therapists in community settings. This information may help supervisors of occupational therapists to provide support to develop professional expertise, avoid burnout, and remain engaged in community practice. Finally, this study provides information of use to occupational therapists considering entering community practice, so they may better understand and prepare for their chosen practice setting, and understand the steps they will need to take to develop and maintain expertise in community practice.
Theoretical Rationale

The theoretical rationale chosen for the study was based on the work of Tynjälä (1999), who synthesized the work of several other models of professional expertise (Frost, 2001; Kennedy, 1987; Yielder, 2004). According to Tynjälä, professional expertise is comprised of a well-integrated body of formal, practical, and reflective knowledge and is characterized by effective problem solving in uncertain situations. Other theories of professional expertise examined for this study include those of Benner (1984), who developed a five-stage model of professional expertise, and Schön (1983), who examined reflective practice. These theories are examined in the following section.

*Formal knowledge* (also referred to as declarative, explicit, or content knowledge) is domain-specific knowledge gained in formal educational settings. This knowledge forms the core of what is usually thought of as professional competence, is universal and explicit, and is the type of knowledge tested for on standardized examinations to determine entry into practice. Until recently, the focus of formal learning in most occupational therapy educational programs has been preparing students for hospital practice. This means that many occupational therapists enter community-based practice lacking needed formal content knowledge (Lemorie & Paul, 2001; Lysack, Stadnyk, Paterson, McLeod, & Krefting, 1995).

*Practical knowledge*, also called situated learning, is experiential, skill-based, situation-specific, and gained over time through apprenticeships, internships, or on-the-job experience. In occupational therapy education, students complete fieldwork hours designed to promote experiential learning in hospitals, clinics, and schools. Few
occupational therapists, however, have community-based fieldwork experiences prior to working in community settings. Because of this, they may lack needed practical skills. “Communities of practice” comprised of professional peers and mentors typically help new practitioners learn the skills, roles, and values of their profession (Lave & Wenger, 1991, p. 29). Because community-practicing occupational therapists often practice in relative isolation, they are not typically part of these communities of practice.

Reflective knowledge, also known as metacognition, is developed through active reflection on professional problems and consideration of all possible solutions (Schön, 1983). Professionals attempt to frame a complex, uncertain, and often-messy problem, apply previous knowledge to the problem, and solve the problem through trying out multiple possible solutions in collaboration with the client (Schön, 1983). Reflective practitioners are better able to self-monitor and self-correct than nonreflective practitioners. In community-practice settings that lack other resources to foster professional development, reflective practice may be an especially critical component of professional expertise (McColl, 1998), yet little emphasis has been placed on fostering reflective practice in formal academic preparation programs.

Clinical reasoning integrates formal, practical, and reflective knowledge through a continuous process designed to foster effective problem solving and decision-making in clinical practice settings (Mattingly & Fleming, 1994; Unsworth, 2001). Clinical reasoning in occupational therapy differs from the clinical reasoning used in medicine to diagnose and treat diseases because occupational therapy as a practice differs significantly from clinical medical practice. While clinical medicine is
concerned with diagnosis and treatment of medical conditions, occupational therapy is concerned with helping the client learn or relearn everyday activities to improve quality of life, plan for the future, and understand the meaning of the disability experience (Mattingly & Fleming, 1994; Unsworth, 2001). Occupational therapists use continuous rather than sequential reasoning and individualized rather than standardized approaches to treatment, including the client in the decision-making process and offering choices to the client.

Many types of clinical reasoning are typically used in occupational therapy practice; however, the major categories are procedural, interactive, narrative, and conditional reasoning (Mattingly & Fleming, 1994). Procedural reasoning focuses on the how-to aspect of treatment or intervention, including diagnosis, problem identification, intervention planning, and intervention. Interactive reasoning focuses on the development of a therapeutic relationship with the client, while narrative reasoning is used to help the client tell a story about the disability and meaning of the disability in his or her life. Conditional reasoning helps the therapist and client plan for the future and consider the if–then aspect of treatment. Through clinical reasoning, occupational therapists seek to understand and solve the therapy problem and help clients obtain therapeutic goals. Frequent use of interactive and conditional reasoning approaches represent a higher level of professional expertise for occupational therapists because these approaches help therapists and clients build positive therapeutic alliances and plan actively together for the future (Unsworth, 2001).
According to Benner (1984), professional expertise is typically developed sequentially over time, as practitioners pass through five levels of proficiency: novice, advanced beginner, competent, proficient, and expert. These different levels of expertise reflect changes in aspects of skilled performance, from reliance on abstract principles to use of experience, from reductionistic to holistic perspectives, and from detached to involved performance.

Novices have limited experience, use ineffective cognitive strategies, and rely on rules, role models, and procedures to help them perform acceptably. Novices tend to reason backward, starting with a general conclusion and attempting to reason back to the problem. Novices typically use formal learning experiences such as classes to extend their knowledge and benefit from close supervision or mentoring. Novices, lacking experience, are more reliant on formal knowledge and less able to discern relevant information and generate effective solutions to complex, real-life problems (Etringer & Hillerbrand, 1995).

At advanced beginner and competent levels of practice, professionals have some store of previous experience to draw on and begin to develop more flexible and effective problem solving skills. Competence follows 2 to 3 years of practice, when individuals can see the positive benefit of their actions. They are also able to plan more proactively and manage multiple tasks. Proficiency is typically associated with the 5 year level of practice. At this stage, practitioners feel increasingly confident in their clinical skills and judgment (Benner, 1984).

At the expert level, professionals function independently, using knowledge intuitively to make effective clinical decisions in complex situations through focusing
effectively on priorities (Benner, 1984). Experts are able to recognize patterns that have occurred before in practice, have a store of experiences to draw on, and are able to use past experience to guide future behavior. Experts engage in complex forward reasoning, starting with existing information and moving toward the problem. They also have a better ability to solve ill-structured problems because of their use of practical knowledge. At advanced levels of practice, performance is intuitive, learning is situated, and decisions are made on an instinctive level (Benner, 1984; Dreyfus & Dreyfus, 1986).

Stage-specific models of the development of professional expertise have been criticized for being too rigid and for failing to explain adequately the process by which professionals transition through levels of expertise (Tynjälä, 1999). Recent theories of professional expertise focus on the reciprocal relationship between the cognitive and experiential aspects of expertise. These models view knowing and doing as inseparable, and also emphasize the importance of positive interpersonal relationships in professional expertise (Shepard, Hack, Gwyer, & Jensen, 1999; Yielder, 2004). Community-based occupational therapists often lack opportunities for participation in communities of practice and have limited access to professional mentoring. In order to develop professional expertise, they may rely more on experiential learning and other approaches. One of the purposes of this study was to explore this issue further.

Background and Need

The profession of occupational therapy began in psychiatry in the early 1900s, when persons with mental illness were typically confined to large asylums for
indefinite periods. With no effective psychotropic medications, few patients recovered sufficiently to return to their families and communities. Patients were often subjected to inhumane treatment and periods of forced inactivity. Occupational therapy interventions grew from the observation that patients who were “occupied” with useful tasks seemed to recover their health more quickly than those who were not. Early occupational therapy was heavily craft oriented; occupational therapy workshops featured weaving, basket making, chair caning, woodworking, gardening, and a variety of other activities valued for their psychologically restorative effects. Early occupational therapists were experts at handcrafts, at matching the needs of the client to the appropriate activity, and at adapting activities to meet the needs of the client. They were also expert at helping individuals adapt to life in institutional settings, since many patients never returned to community living (Schwartz, 2005).

Between 1914 and 1945, World Wars I and II served to focus occupational therapy practice on the rehabilitation of wounded soldiers. Occupational therapy as a profession became allied with physical medicine, and biomedical paradigms replaced biopsychosocial paradigms. Occupational therapists became experts on the medical aspects of specific disabling physical conditions and their functional implications. Intervention focused on remediating disability, often through biomechanical exercises. Fewer occupational therapists addressed the psychosocial concerns of their patients. Although more occupational therapists focused on returning their patients to community life, occupational therapy practice remained located primarily in hospitals and other institutional settings such as schools and skilled-nursing facilities (Quiroga, 1995).
Today, occupational therapy practice emphasizes a client-centered, occupationally based approach to treatment. Community care, focusing on wellness and health promotion, is viewed as the best-practice model of the present and the future (AOTA, 2005). Community practice demands a different type of professional expertise than institutional practice. Community-practicing occupational therapists are expected to be mature, independent professionals and to be experts at helping clients live and work independently. Community-practicing occupational therapists often assume multiple professional roles such as such as case manager, client advocate, grant writer, and community-living specialist (Dougherty, 1994). They need knowledge and skills in areas such as consultation, program development, and community advocacy that, until recently, were not taught in academic occupational therapy programs (Lemorie & Paul, 2001; Lysack, Stadnyk, Paterson, McLeod, & Krefting, 1995).

Occupational therapy education programs today are beginning to use a variety of approaches to teach community-practice skills to students. These approaches include increasing students’ formal knowledge through curricular changes; increasing their practical knowledge through internship, fieldwork, and community projects; and increasing their reflective knowledge through journaling, group supervision, and online discussion group activities (Bossers, Cook, Polatajko, & Laine, 1997; Robnet, 1997; Scott, 1999). Minimum degree requirements for occupational therapy have been moved to the postbaccalaureate level to help ensure that occupational therapists acquire the necessary knowledge and skills for independent professional practice. Accreditation standards now require course content in health promotion, program
Fieldwork experiences, sometimes referred to as internships, are being used to prepare students for community practice (Borcherding & Baldwin, 2001). Fieldwork experiences constitute a form of practical knowledge, connect theory to practice and classroom to clinic (AOTA, 2004), and are a standard component of all professional programs. Occupational therapy students complete over 1,000 hours of supervised fieldwork as part of their formal education (ACOTE, 1998). Fieldwork experiences in occupational therapy have historically used a preceptor model, in which students are mentored one-on-one in a clinical setting such as a hospital, clinic, or school. During the fieldwork experience, the role of the occupational therapist is clearly defined, and direct supervision is provided by an occupational therapist.

Occupational therapy educators now place students at nonmedical community sites such as homeless shelters, day care centers, prerelease corrections centers, camps for special needs children, and senior centers. In these sites, supervision is typically provided on-site by non–occupational therapy health care professionals. Students in these settings are expected to function more independently than they would in a traditional hospital setting (Scott, 2000). Many of these placements also require an active self-reflective process, such as journaling or participating in an online chat room designed to promote reflective knowledge.

Community-based clinics where students develop and lead wellness and health-promotion groups have recently been added to many academic programs (Scott, 1999). Grant-funded community programs have been developed in partnership
with community agencies (Walens, Helfrich, Aviles, & Horita, 2001), and community-based research projects are exploring how academic programs and communities can work together to advance knowledge, train professionals for community practice, and provide needed community services (Braverman, Helfrich & Fisher, 2001).

Despite these recent educational efforts, significant barriers to the development of professional expertise in community practice still exist. Although health professions education programs recognize the need to train students for community practice (Kemp, 2003; O’Neill, 1992), lack of adequate academic preparation is a problem in many health disciplines, including nursing, physical therapy, and medicine (Chalmers, Bramadat, & Andrusyszyn, 1998; Lysack, Stadnyk, Paterson, McLeod, & Krefting, 1995). In occupational therapy, most education programs still focus on teaching clinical skills primarily used in hospital settings, such as measuring range of motion and muscle strength, and neglect more community-oriented skills such as case management and client advocacy. Community-based occupational therapists often do not feel adequately prepared by their educational programs for the challenges of community practice (Lemorie & Paul, 2001; Lysack, Stadnyk, Paterson, McLeod, & Krefting, 1995). Occupational therapists trained in institutional models of practice must adapt these models to community practice in order to be effective (McColl, 1997).

Lack of community-based internship sites is another barrier to educating students for community practice. Community-practicing occupational therapists are reluctant to supervise students, partly due to what they see as the nontraditional, non–
institutionally based nature of their work. Therapists working in community settings are often the only occupational therapist on the team and assume multiple professional roles as part of their job responsibilities (S. Degen, personal communication, November 2005). All of these issues may make them reluctant to supervise students. The shortage of community fieldwork placements creates a negative spiral of fewer occupational therapists choosing to enter community practice (Lewicki, Smith, Cash, Madigan, & Simons, 1999). The shortage of community-practicing occupational therapists also means that no theories or models have been developed to guide practice. Professional mentors for new therapists are often unavailable, and community-practicing occupational therapists are seldom recognized or rewarded for their work.

Lack of research on community-based practice is another concern. While community-based occupational therapy has been the subject of position papers and textbooks (Adams, 1991; Kronenberg, Algado, & Pollard, 2005; Robnet, 1997; Scaffà, 2001), a limited number of systematic research studies of community practice in occupational therapy have been undertaken. There is a general lack of understanding about what constitutes effective community occupational therapy practice (McColl, 1997).

Clinical reasoning in community-based occupational therapists has been examined in a limited number of studies. Ward (1996, 2003) examined expertise and clinical reasoning in community mental health occupational therapists, using a qualitative phenomenological approach. Alvernik and Sviden (1996) found that community-practicing occupational therapists in Sweden used clinical reasoning
skills effectively to help clients with serious mental illness achieve higher levels of community function, including work. These studies, however, are limited in number and scope. More research is needed to understand the development of professional expertise in community-practicing occupational therapists.

Occupational therapy as a profession has evolved greatly since its inception. As occupational therapy increasingly moves into community-practice models based on wellness and health promotion, new types of professional expertise are needed. The current study explored the experience and meaning of professional expertise for community-practicing occupational therapists.

Research Questions

1. What constitutes professional expertise in community-practicing occupational therapists?

2. What combination of formal, practical, and reflective knowledge is used by community-practicing occupational therapists?

3. What types of clinical reasoning are used by occupational therapists in community practice?

4. What factors support or inhibit the development of professional expertise in community practice?

Figure 1 provides a graphic representation of the concepts being considered in the proposed study and their relationship to one another.
Figure 1. Professional expertise and clinical reasoning in occupational therapy
Definition of Terms

*Community practice:* For the study, community practice is occupational therapy that takes place in a community setting and not in an institutional setting such as a hospital or skilled-nursing facility. It is practice that is client-centered, nonmedical, and wellness oriented (Scaffa, 2001). It may involve helping the client with social, vocational, or housing needs that serve to promote optimal occupational adaptation and community tenure.

*Professional expertise:* For the study, professional expertise is defined as formal, practical, or reflective knowledge that enables practitioners to perform their professional roles and responsibilities (Tynjälä, 1999). Expertise can be manifested at novice to expert levels. Evidence of professional expertise for this study will be assessed via participant statements or behaviors that reflect use of formal, practical, or reflective knowledge and other elements of professional expertise, as defined in the literature.

*Clinical reasoning:* For the study, clinical reasoning is defined as the thought processes used by the participants to understand client issues, explore problems, and generate solutions that help clients achieve their goals. Clinical reasoning involves the integration and synthesis of all three forms of knowledge constituting professional expertise. Evidence of clinical reasoning used by participants in this study was sought and evaluated via evaluating statements made and categorizing them into one of the four clinical reasoning categories: procedural, interactive, narrative, and conditional (Mattingly & Fleming, 1994).
a. Procedural reasoning focuses on the how-to aspects of treatment or intervention, including diagnosis, problem identification, intervention planning, and intervention.

b. Interactive reasoning focuses on the development of a therapeutic relationship with the client.

c. Narrative reasoning is used to help the client tell a story about the meaning of the disability in his life.

d. Conditional reasoning helps the therapist and client plan for the future and considers the variables involved in living with a disability.
CHAPTER TWO

REVIEW OF THE LITERATURE

This section is organized into three areas. First, concepts of professionalism and professional expertise are defined and explored, and conceptual studies of professional expertise are reviewed. Second, research studies on professional expertise in occupational therapy and related disciplines are examined. The section concludes with an examination of phenomenological research studies of the experiences of occupational therapists.

Concepts of Professional Expertise

*Professions* are defined as highly specialized occupations requiring advanced education and degrees (Frost, 2001). Professionals must typically pass state or national board examinations designed to determine if minimum standards for entry-level practice have been met. Most professions are licensed and regulated, both by governing bodies and by professional associations. *Professional expertise* is loosely defined as outstanding performance in a domain of practice (Ericsson, 1991). Concepts of professional expertise have primarily emerged from the education field, particularly the fields of adult and continuing education. Professional expertise requires the ability to synthesize formal, practical, reflective, and interpersonal knowledge and skill (Tynjälä, 1999; Yelder, 2004), and is generally developed through a stage-specific process over time (Benner, 1984; Dreyfus & Dreyfus, 1986). At the expert level, professionals effectively use a variety of cognitive and metacognitive strategies, including clinical reasoning, to solve complex practice problems (Etringer & Hillerbrand, 1995; Mattingly & Fleming, 1994).
Yielder (2004) studied medical-imaging technicians in order to develop a model of professional expertise that integrates both cognitive and experiential components. The purpose of the study was to evaluate existing models of professional expertise, demonstrate that the theoretical knowledge base and cognitive development of professionals cannot be separated from practice, and advance an integrated model of expert professional practice. A case-study research method was used, consisting of two interviews and journaling of critical incidents over an extended period of time, to collect data from 10 expert medical-imaging professionals. Critical incidents are unusual or nonroutine aspects of a particular situation in which either the provider or the patient might have a strong emotional response, or there is a potential outcome that may significantly affect the life and health of the patient.

Through a critical analysis of the data, Yielder identified five dimensions of practice that she used to build a conceptual model of professional expertise. These dimensions are labeled knowledge base, cognitive processes, internal integrative processes, interpersonal relationships, and professional practice. Professional practice is the central concept of this model that integrates all the other concepts. Expert practice requires the integration and application of all five dimensions of practice. In order for professionals to continue to develop expertise, they need to maintain an open and critical approach to their knowledge and practice. This critical approach may help certain individuals develop into experts in their field, while others remain merely competent or even regress in their level of professional expertise, despite years of experience (Yielder, 2004).
Yielder also discussed implications of her findings for higher education. According to Yielder, professional education programs should be expanded beyond the mere teaching of technical skills to include competencies in communication, problem solving, team work, and self-management. Reflective practice should be actively promoted to help professionals develop critical thinking skills that will enable them to respond appropriately to situations arising in uncertain practice environments.

Etringer and Hillerbrand (1995) reviewed empirically based literature on counselor development to examine the transition from novice to expert counselor, specifically what differentiates the cognitive processes of novice and expert counselors. Their goal was to reconceptualize counselor development as a change process and to better understand and define that process. They found that experts use a variety of cognitive and metacognitive strategies to structure and solve complex problems, including procedural knowledge, pattern recognition, and complex reasoning. While both novice and expert professionals possess the formal, declarative knowledge gained in the classroom, experts have also acquired procedural knowledge over time with experience, practice, and feedback. Unlike novices, experts have a store of experiences to draw on, are able to recognize patterns that have occurred before in practice, and are able to use past experience to guide future behavior. Experts have a better ability to solve ill-structured problems because of their use of practical knowledge. Novices, lacking experience, are more reliant on formal knowledge and may be less able to discern relevant information and generate effective solutions to complex, real-life problems.
Professionals develop expertise in a variety of ways. Dreyfus and Dreyfus (1986) proposed a five-stage model of professional skill development, hypothesizing that people pass through five sequential levels of proficiency: novice, advanced beginner, competent, proficient, and expert. The different levels reflect changes in aspects of skilled performance, from reliance on abstract principles to use of experience, from reductionistic to holistic perspectives, and from detached to involved performance. At advanced levels of practice, performance is often intuitive, learning is situated, and decisions are often made on an instinctive level (Dreyfus & Dreyfus, 1986). Benner (1984) applied the five-stage model to the profession of nursing, as outlined in Table 1.

Benner examined each stage of professional development, categorized the significant aspects of professional skill development that take place at each stage, and identified some of the implications for teaching and learning at each stage. Benner conducted interviews with 21 pairs of novice and expert nurses from three hospitals. Each pair consisted of a newly graduated nurse and her preceptor. They were each asked separately about patient care situations they had in common and about critical incidents that stood out for them. Individual interviews were also conducted with 67 other nurses with varying levels of experience, in order to further delineate stages of skill acquisition. Brief participant observations were made of 26 of the interviewed nurses.

Interview and observation transcripts were read independently by research team members, and interpretations were compared and consensually validated (Benner, 1984). Data were interpreted using a strategy based on Heideggerian
phenomenology and using a constant comparative method (Strauss & Corbin, 1998) to identify meanings and content. Benner found that novices, having limited experience, tend to rely on rules, role models, and procedures to help them perform acceptably. Novice learners typically benefit from formal learning experiences such as classes and from close supervision or mentoring.

Those at advanced beginner and competent levels of practice have some store of previous experience to draw on and begin to develop more flexible and effective problem-solving skills. Competence follows 2 to 3 years of practice, when individuals can see the positive benefit of their actions, are able to plan proactively, and can and manage multiple tasks. Competent professionals benefit from case conferences and coaching to develop clinical reasoning skills, and from assistance in prioritizing tasks. In community-practice settings, occupational therapists typically have fewer opportunities for peer mentoring and are often expected to assume complex job responsibilities as soon as they are hired.

Proficiency is typically associated with the five year level of practice. At this stage, individuals feel more confidence in their clinical skills and judgment, and benefit from best/worst-practice exemplars as well as coaching. At the expert level of 10 or more years’ experience, professionals function independently, using knowledge intuitively to make effective clinical decisions in complex situations through focusing on priorities (Benner, 1984). They can be mentors for students and new professionals, are able to pass on knowledge to others through teaching and leadership positions, and help define best practice for the field.
<table>
<thead>
<tr>
<th>Stage</th>
<th>Length of Experience</th>
<th>Significant Characteristics</th>
<th>Teaching/Learning Implications</th>
</tr>
</thead>
</table>
| Novice        | None to minimal, new graduate through first year of practice | Focus on rules, procedures
Limited repertoire of experience
Inflexibility
Reliance on others | Need for close supervision and, mentoring
Provide explicit structure and support
Formal learning situations work best |
| Advanced Beginner | 1 to 3 years       | Marginally acceptable performance
Some practice-based experience
Still developing | Provide guidelines for learning
Need help setting priorities
Coaching to develop clinical reasoning skills |
| Competent     | 3 to 5 years        | Can formulate actions based on experience
Sees patterns, salient features
Can prioritize tasks
Lack speed and flexibility of expert | Benefit from case conferences that promote decision making
Need to learn how to plan and coordinate complex job responsibilities |
| Proficient    | 5 to 10 years       | See situations holistically rather than in parts
Understand larger implications of treatment decisions
Able to modify treatment based on past experience | Benefit from case studies and examples of interventions
Avoid overly theoretical approaches |
| Expert        | 10 or more years    | Do not rely on explicit analysis of data
More intuitive, holistic approach
Based on a wealth of experience
Display “deep understanding” of complex situations | Systematic documentation of expert performance valuable
Qualitative methods may uncover expert clinical reasoning processes
Serve as consultants and mentors for others |

Adapted from Benner, 1984
The five-stage developmental model has been widely viewed as an accurate representation of how professionals develop expertise. Some researchers, however, have disputed aspects of the model. Some dispute the notion that experts are inherently less analytical, more intuitive, and more holistic than are novices (Yielder, 2004). Others view professional expertise as an iterative process, stressing that expertise is developed over a lifetime of professional practice and must be continually reviewed and revised through lifelong learning and active reflection (Frost, 2001). While the Benner model has also been used to study expertise in occupational therapists, most of these studies have been conducted in institutional settings (Mattingly & Fleming, 1994; Rosa & Hasselkus, 2005; Unsworth, 2001) or in countries with health care systems that differ significantly from the health care system of the United States (Gahnström-Strandqvist, Tham, & Josephsson, 2000). More research is needed to determine whether the Benner model can help explain the development of professional expertise in community settings, which is one aim of the proposed study.

Conceptual models of professional expertise share several common characteristics (Benner, 1984; Etringer & Hillerbrand, 1995; Tynjälä, 1999; Yielder, 2004). They identify the different types of knowledge that comprise professional expertise as formal, practical, and reflective. They see professional expertise as developing over time and in stages. They acknowledge that effective interpersonal skills are essential for professionals to interact with their clients, their professional colleagues, and the public. They recognize that it is the responsibility of professional preparation programs to promote the development of professional expertise through a
variety of educational strategies, including the creation of constructivist and
experiential learning environments. Finally, they articulate the importance of
communities of learning and continuing education as necessary components for the
development and maintenance of professional expertise (Lave & Wenger, 1991).

Research on Professional Expertise

This section will review research studies of novice-to-expert skill
development, studies of professional expertise in community-practicing occupational
therapists, and studies of clinical reasoning as an element of professional expertise in
occupational therapy practice.

Tryssenaar and Perkins (2001) studied occupational and physical therapy
students to gain an understanding of their transition to practice and to identify key
behaviors and value shifts in the respondents. All students in the 1996 graduating
classes of physical therapy and occupational therapy students at McMaster University
in Ontario (N=120) were invited to participate in the study. Participants were asked to
keep reflective journals through their first year of practice and to submit the journals
for later analysis. While 12 students agreed to participate, only three occupational
therapy and three physical therapy students ultimately maintained reflective journals
during their entire first year of professional practice. Participants were asked to write
regularly at unspecified intervals and to submit the journal entries monthly to the
researchers, who then responded with written comments and questions.

Data were analyzed separately by each researcher and by an independent third
reader to develop agreement about major stages and themes in the first-year
experiences of the participants. Each researcher read the journals submitted during the
study independently, and then all the readers consulted to develop consistent themes for subsequent data analysis. A selective highlighting approach, as suggested by van Mannen (1990), was used to identify themes. Four consecutive stages of the first year of practice were identified by the researchers: transition, euphoria and angst, reality of practice, and adaptation (Tryssenaar & Perkins, 2001). Transition and euphoria were experienced by students as they looked forward to graduation and their first job. Angst set in with the reality of practice, but eventually students adapted to the new demands of their work.

Recurring themes were also identified and compared with published first-person accounts of the first year of practice. The six themes that emerged from the data were labeled great expectations, competence, politics, shock, education, and strategies. Great expectations dominated during final clinical placements and into the first job, as participants looked forward to earning a steady paycheck and increasing their professional status. Competence themes emerged early and often as participants expressed doubts about their abilities and struggled to apply what they had learned in school. Another theme that emerged was labeled politics, as participants reflected on the realities of working in organizations and dealing with documentation requirements. Shock was a significant theme as the students encountered the realities of the workplace, including demands for higher productivity and resulting increased personal stress levels. The final theme of strategies was reflected in comments made starting the fourth to sixth month of practice, as participants began to develop methods to help them cope with the realities of practice. These included both personal
and professional coping strategies, such as taking more time for themselves at home and staying up-to-date on new research in the fields.

Students and recent graduates are novice practitioners who often use ineffectual cognitive strategies, have unrealistic expectations of practice, and experience significant stress as they adjust to new professional roles. The researchers suggested that since the transition from student to therapist is a difficult one, more should be done to help prepare students for the realities of practice. Providing professional mentors, opportunities for continuing education, and opportunities for structured reflection, especially in community-practice settings, were some of the suggestions made by the authors for easing the transition from student to professional (Tryssenaar & Perkins, 2001).

Daley (1999) explored differences and similarities in learning styles and cognitive strategies between novice and expert nurses. Participants were 10 novice and 10 expert nurses selected via a purposive sampling process while attending a continuing professional education program. Data collection methods consisted of structured interviews and clinical narratives. Subjects were interviewed once for 1 to 2 hours. Additionally, they were asked to write a clinical narrative that described actual cases where they felt learning had occurred. Clinical narratives were used to triangulate with other data collected and to differentiate novice from expert therapists.

Data were analyzed using the constant comparative method of Strauss and Corbin (1998). Constant comparative methods are used in grounded theory to compare new data against developing themes. Another data analysis method used was the construction of concept maps visually representing relationships between key
themes and concepts. A set of codes emerged from the concept maps, and the codes were used to construct a computerized data analysis system to do side-by-side comparisons of novice and expert nurses.

While no report was given of the total number of themes identified through the data analysis process, the findings indicated that novices learn better through formal mechanisms, while experts learn through informal learning mechanisms. Novice learners in the study focused on concept formation and not making mistakes. They needed and sought validation from superiors about the appropriateness of their decisions, and benefited from structured learning such as courses, lectures, and guided review of policy manuals. Experts in the study were more self-directed and constructivist in their approach to learning than novices. They sought out informal learning situations such as consultation with colleagues, rather than continuing education courses. Experts quickly assimilated new experiences with previous experiences, learning through dialogue with others. A main theme that emerged is that the nurses “learned how to learn” within the context of their practice (Daley, 1999). Since community-practicing occupational therapists do not always have structured learning opportunities available to them, it might be harder for them to develop professional expertise along the usual novice–expert continuum.

Daley (1999) also identified factors that hindered or supported learning in novice and expert nurses. Factors that hindered learning for novices included lack of in-service training, time constraints, and personality conflicts. Experts were more likely to identify systemic issues such as resources, politics, and organizational structure as barriers to learning. The author concluded that situated learning, or
learning that takes place in the setting where the skills are needed and used, might be the best way to develop expertise in practice professions. Situated learning is an approach to teaching and learning that is based on the assumption that knowledge is in part a product of the activity, context, and culture in which it is developed and used. Cognitive apprenticeships that embed learning in context enable people to learn effectively (Brown, Collins, & Duguid, 1989). Because community occupational therapy practice represents a context that differs significantly from hospital practice, it may be that situated learning is an essential element in the development of professional expertise for community-practicing occupational therapists.

Studies of professional expertise in community-practicing occupational therapists show significant gaps between educational preparation and the requirements of community practice. Lysack, Stadnyk, Paterson, McLeod, and Krefting (1995) surveyed community-practicing occupational therapists in Canada about professional expertise. The overall purpose of the study was to increase the number of competent community rehabilitation practitioners. The specific aims of the study were threefold: to survey community therapists regarding perceptions around community therapy and educational preparation for it, to develop and evaluate a multidisciplinary course for undergraduate rehabilitation therapy students, and to develop and evaluate training materials for community fieldwork supervisors enhancing their ability to prepare students for community practice. Community occupational therapy was defined as services that are client-related, consultative, educational, coordinating in nature, and typically offered outside a building designated as an institution (Lysack, et al., 1995).
A 27-item survey called the Community Practice Profile Survey (CPPS) was used to collect the data. The CPPS included fixed-response and open-ended questions. Criteria for participation in the study were established by using the employment categories of the 1991 membership of the Canadian Association of Occupational Therapists (CAOT). Thus occupational therapists who self-identified as community-practitioners were eligible to participate in the study. In order to increase the proportional representation of therapists practicing in areas such as industry, retail, and private practice, the sample was weighted to include therapists in all employment categories. Of the 552 CAOT members who met the eligibility criteria, a weighted sample of 200 were selected for the survey.

Survey questions asked respondents to identify professional skills and professional roles they needed and used in community practice. They were also asked how well they believed their formal education prepared them for specific community-oriented skills and roles. Professional skills included items such as written and verbal communication, networking, client assessment, staff education, and consultation. Professional roles included categories such as clinician, consultant, case manager, and administrator. Of the 200 surveys sent out, 130 were returned, for a response rate of 65%. Data were analyzed both quantitatively and qualitatively. Written responses were qualitatively analyzed for recurring themes. Respondents reported they often assumed multiple professional roles for their jobs, including clinician, case manager, consultant, and educator. Respondents reported several professional skills as critical for community practice, including client-centered practice, consultation, clinical
reasoning, client advocacy, health promotion, and knowledge of community resources,

Study results are summarized in Table 2. Many respondents felt their educational programs did not prepare them adequately for community practice. Respondents indicated a strong belief in the relationship between quality fieldwork experiences and effective community practice. Further, they indicated a belief that community fieldwork placements should be required for all occupational therapy students. Respondents also suggested that community-practicing therapists could contribute to the development of community practice content in academic programs.

Lemorie and Paul (2001) replicated the CPPS study (Lysack, Stadnyk, Paterson, McLeod, & Krefting, 1995) in the United States with changes made to reflect American systems of care and other cultural differences. The authors of the original study reviewed the revised survey for face validity. The purpose of the study was to help identify job roles, job skills, and professional expertise of occupational therapists practicing in the community. Inclusion criteria for selection consisted of membership in the American Occupational Therapy Association, practice in the state of Michigan, Illinois, or Indiana, and self-identification as a community-practicing occupational therapist. Respondents were recruited from all practice areas, and schools, home health agencies, and community mental health centers were included as sites of community practice. Two hundred occupational therapists who met the selection criteria were randomly selected to receive the survey. Of the 200 surveys mailed, 84 were returned, for a 42% response rate.
Table 2. Comparison of Two Studies Regarding Community Practice in Occupational Therapy

<table>
<thead>
<tr>
<th></th>
<th>Study 1</th>
<th>Study 2</th>
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</thead>
<tbody>
<tr>
<td>Date of Study</td>
<td>Lysack, et al.</td>
<td>Lemorie</td>
</tr>
<tr>
<td></td>
<td>1995</td>
<td>2001</td>
</tr>
<tr>
<td>Study Location</td>
<td>Canada</td>
<td>USA</td>
</tr>
<tr>
<td>Subjects (n)</td>
<td>130</td>
<td>84</td>
</tr>
<tr>
<td>Job Skills</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Needed</td>
<td>Taught</td>
</tr>
<tr>
<td>Consultation</td>
<td>94%</td>
<td>21%</td>
</tr>
<tr>
<td>Self-directed learning</td>
<td>92%</td>
<td>16%</td>
</tr>
<tr>
<td>Networking</td>
<td>94%</td>
<td>16%</td>
</tr>
<tr>
<td>Accessing community resources</td>
<td>90%</td>
<td>30%</td>
</tr>
<tr>
<td>Job Satisfaction</td>
<td>90%</td>
<td>94%</td>
</tr>
<tr>
<td>Multiple job roles</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Recommend more education for community practice</td>
<td>85%</td>
<td>91%</td>
</tr>
</tbody>
</table>

Quantitative data were analyzed descriptively with frequency tables, and responses to specific items were compared to the previous study. Skills and expertise identified by respondents were grouped into three categories: 1) interpersonal skills, 2) clinical skills, and 3) community-specific skills. Interpersonal skills encompassed areas such as written and verbal communication, consultation, staff education, and client advocacy. The findings generally corresponded with the findings of Lysack et al. (1995). See Table 2 for more detailed results. Respondents stated they felt well prepared to use standard clinical skills such as assessment, documentation, and charting, but less well prepared for skills needed in community practice. These included the use of client-centered approaches, self-directed learning, and clinical reasoning. Another key finding was in the area of professional roles, where significant professional role blurring was reported by the respondents. They reported being asked to serve as consultants and educators as well as clinicians. Role blurring and role strain occur when individuals with one set of professional skills are required to perform skills more typical of another profession (Smith & Roberts, 2005).

Six community-specific skills were identified by study participants as critical to expertise in community practice. These were networking, community resources, management of volunteers, program evaluation, health promotion, and multicultural practice issues (Lemorie & Paul, 2001). The majority of respondents indicated a high degree of satisfaction with community-based practice but felt that the educational system did not adequately prepare them with needed professional skills. Respondents suggested that academic programs provide more preparation for community practice, as well as continuing education opportunities.
The findings of these studies highlight the significant perceived discrepancy between the professional skills required of community-practicing therapists and their academic preparation. Both studies found that occupational therapists in the community are struggling to succeed in a practice area for which they have received little formal preparation (Lemorie & Paul, 2000; Lysack et al., 1995). The authors suggested that more research into the professional expertise of community-practicing occupational therapists is also warranted. Interestingly, some respondents in the Lemorie and Paul study did not support the development of fieldwork placements in community settings. They saw community practice as an advanced practice area and felt that students would benefit from initial training in more traditional (institutional) occupational therapy practice settings.

Clinical reasoning as an element of professional expertise has been significantly studied in occupational therapy. Mattingly and Fleming (1994) conducted an ethnographic and action research study of clinical reasoning with occupational therapists at an acute care hospital. The primary purpose of the study was to discover and describe clinical reasoning in occupational therapy practice, using naturalistic investigation methods rather than quantitative methods. For the study, 14 occupational therapists representing a range of specializations, including neurology, oncology, spinal cord injury, psychiatry, and hand therapy, were recruited from the occupational therapy department of a 900-bed hospital. Participants in the study represented many levels of experience, from novice to expert.

The study was conducted over a period of 2 years, and data were collected in three ways: observations, in-depth interviewing of patients and therapists, and
videotaped clinical sessions between therapists and patients. Therapists were interviewed before and after therapy sessions and asked to describe their reasoning in their work with clients. Therapists also viewed videotapes of their therapy sessions and were asked to reflect on their clinical reasoning process. They were asked about things such as key decision points, surprises, areas of frustration, and underlying assumptions or theories that supported their reasoning. Over 2,000 pages of field notes and transcripts were collected, as well as 30 videotapes of clinical sessions. As part of the study, the researchers spent time with the therapists at staff meetings, in the break room, and viewing and discussing cases. Participants were asked to describe in detail stories of their sessions with clients, and to reflect on their experiences.

The data were analyzed by both the researchers and the therapists, using narrative modes of analysis. Narrative analysis focuses on revealing cultural and social patterns through the lens of individual experiences (Patton, 2002) and is extensively used in the fields of medical sociology and medical anthropology. Narrative analysis usually involves looking at the unit of analysis as a story having a dramatic flow, a plot, and a cast of characters. One data analysis strategy used in the Mattingly and Fleming (1994) study was to have all members of the group view a videotaped treatment session and then tell their version of the events. They were asked to view the treatment as a story with chapters and a dramatic flow, to identify the different actors in the process, and to identify central themes in the story. Because of this process, the participants reported becoming more aware of the assumptions they were making about the lives of their patients and about what mattered to the
patients, rather then just focusing on traditional medically oriented therapy goals (Mattingly & Fleming, 1994).

A major outcome of the study was the identification of types of clinical reasoning used in occupational therapy practice. These were named procedural, interactive, narrative, and conditional reasoning, and are described further in Table 3. Procedural reasoning is used to solve technical problems and formulate treatment plans and strategies based on diagnosis. Interactive reasoning focuses on the relationship with the client and on the experience of the disability from the client’s perspective. Narrative reasoning helps the client “tell a story” about the disability and understand the meaning of the disability in the larger context of his or her life. Conditional reasoning helps the therapist and client make meaning of the experience and plan for the future. While all the participants in the study used multiple forms of clinical reasoning, novice therapists tended to use more procedural reasoning than did expert therapists. Expert therapists were seen as making complex action look simple through two key factors: breadth of experience and depth of reflection. Much expert practice in occupational therapy has been unarticulated and has thus remained in the realm of tacit practice. One aim of the Mattingly and Fleming study, as well as the proposed study, is to examine and explore the individual expertise of practitioners in order to improve the expertise of the profession as a whole.

The participants in the Mattingly and Fleming study reported becoming more aware of their own clinical reasoning skills and processes through the process of participation in the study. Study participants also acknowledged the constraining forces of the institutional hospital context on their practice. For example, although
participants wished to address client concerns about the meaning of their illness and disability experience, they felt constrained by documentation and reimbursement pressures to confine their practice to a medical model of care. Because of this, creative solutions that fell outside of medically sanctioned treatment models were seldom used. Community-practicing occupational therapists, in contrast, typically work outside the medical model and thus have opportunities to help their clients achieve independence through a variety of creative solutions, such as supported housing and supported employment. Study participants worried about how their treatment interventions might be viewed by other professionals and about whether their treatments would cross into other professional “turf.”

Community-practicing occupational therapists, in contrast, often report needing to assume generalist roles and expand their professional responsibilities beyond traditional occupational therapy tasks. Some community practicing occupational therapists report experiencing role strain and dissatisfaction related to the variety of nonstandard work activities they are asked to undertake (Lloyd, King, & McKenna, 2004).

While the Mattingly and Fleming study was a significant one for the field of occupational therapy and helped advance understanding about the clinical reasoning skills of occupational therapists, only 14 therapists participated, representing a very limited sample. The acute care hospital setting represented another limitation of the study. Clinical reasoning in community settings might be different from clinical reasoning in hospital settings, since community practice is so different from hospital practice.
<table>
<thead>
<tr>
<th>Type of Reasoning</th>
<th>Distinguishing Characteristics</th>
<th>Application</th>
</tr>
</thead>
<tbody>
<tr>
<td>Procedural</td>
<td>Use of a clinical hypothesis</td>
<td>Search for the “right” technique or procedure to use</td>
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<tr>
<td></td>
<td>Reliance on diagnostic</td>
<td>Development of treatment plan</td>
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<td></td>
<td>categories</td>
<td>Selection of modalities and interventions</td>
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<td></td>
<td>Focus on problem solving</td>
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<tr>
<td></td>
<td>Reliance on knowledge of</td>
<td></td>
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<td></td>
<td>correct techniques and</td>
<td></td>
</tr>
<tr>
<td></td>
<td>procedures</td>
<td></td>
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<tr>
<td>Interactive</td>
<td>Purposeful dialogue with</td>
<td>Client interview and</td>
</tr>
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<td></td>
<td>client</td>
<td>occupational history</td>
</tr>
<tr>
<td></td>
<td>Used to improve ability to</td>
<td>Individualizing treatment</td>
</tr>
<tr>
<td></td>
<td>interact effectively with</td>
<td>to client</td>
</tr>
<tr>
<td></td>
<td>client</td>
<td>Check with client</td>
</tr>
<tr>
<td></td>
<td>Focus on feelings of client</td>
<td>regarding their perceptions of progress</td>
</tr>
<tr>
<td></td>
<td>Focus on the disability</td>
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<tr>
<td></td>
<td>experience of the client</td>
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<tr>
<td>Narrative</td>
<td>Used to develop a “story”</td>
<td>Gives client hope about</td>
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<td></td>
<td>about the disability and the</td>
<td>the future</td>
</tr>
<tr>
<td></td>
<td>future</td>
<td>Creates a unique story</td>
</tr>
<tr>
<td></td>
<td>Places the situation in a</td>
<td>for/about client vs.</td>
</tr>
<tr>
<td></td>
<td>temporal context</td>
<td>generic treatment</td>
</tr>
<tr>
<td></td>
<td>Helps therapist and client</td>
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<tr>
<td></td>
<td>to see the “bigger picture”</td>
<td></td>
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<tr>
<td></td>
<td>of the disability in life</td>
<td></td>
</tr>
<tr>
<td></td>
<td>context</td>
<td></td>
</tr>
<tr>
<td>Conditional</td>
<td>Used to make meaning in the</td>
<td>Ask the client, “How will</td>
</tr>
<tr>
<td></td>
<td>context of culture and</td>
<td>your life be now?”</td>
</tr>
<tr>
<td></td>
<td>society</td>
<td>Intentionality and re-</td>
</tr>
<tr>
<td></td>
<td>Views the client from a</td>
<td>engagement in meaningful</td>
</tr>
<tr>
<td></td>
<td>phenomenological perspective</td>
<td>activity</td>
</tr>
<tr>
<td></td>
<td>Uses imagination to envision a</td>
<td></td>
</tr>
<tr>
<td></td>
<td>positive future for the client</td>
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</table>

Adapted from Mattingly and Fleming, 1999
Unsworth (2001) studied the clinical reasoning abilities of occupational therapists working in physical rehabilitation centers in Australia. The purpose of the study was to examine the differences in clinical reasoning skills of novice and expert occupational therapists. Specifically, the researchers were interested in determining whether expert therapists used clinical reasoning more frequently overall than novice therapists did and whether expert therapists used clinical reasoning more frequently than novices during different phases of therapy, such as assessment, treatment, and discharge planning.

Novice clinicians were considered to have less than 1 year of experience, and expert clinicians had more than 5 years experience and an advanced degree. Three expert and two novice therapist participants agreed to participate in the study. During a therapy session, participants wore a miniature head-mounted video camera attached to a video recorder worn in a waist pouch. This method allowed the participants to view the therapy session from their own visual perspective. They later viewed the recordings with a researcher and commented on their clinical-reasoning processes. The clinical-reasoning sound track was recorded onto a new videotape along with the footage of the therapy session. This method, in effect, allowed the participants to record a voice-over narration for their own therapy session.

The transcripts from the video viewing sessions were blindly coded by two researchers, using categories of conditional reasoning, interactive reasoning, procedural reasoning, and narrative reasoning. Transcripts were then analyzed both quantitatively and qualitatively. Descriptive quantitative data analysis results showed that experts had a higher overall frequency of instances of clinical reasoning than did
novices. While both novice and expert therapists used similar percentages of reasoning during assessment (32% vs. 35%), experts used a higher percentage of clinical reasoning during treatment (34% vs. 41%) and discharge planning (37% vs. 22%).

Qualitative data analysis was done through analysis of the transcripts to examine differences in the clinical reasoning strategies of novices and experts. Findings were that expert therapists overall used more conditional reasoning strategies, drew more on past experiences, and considered client preferences more consistently than novice therapists. Novices also used more procedural reasoning than did experts, confirming Mattingly and Fleming’s findings. Expert therapists described a “flow” process in their therapy versus the segmented descriptions of therapy offered by novices. This was demonstrated by the experts’ greater capacity to reflect on their practice, as seen in the videotape. Experts, with a larger store of knowledge to draw on, were also more confident of their knowledge and skills, more client centered, and better able to accept the limitations inherent in practice situations than were novices. Narrative excerpts of expert therapist clinical reasoning were used to illustrate key findings.

The researchers concluded that effective clinical reasoning skills are critical for all occupational therapists and suggested that expert therapists could help novice therapists develop better clinical reasoning skills by using activities such as discussion and reflective journaling. The researchers also believed that the qualitative data analysis procedures used were better at revealing differences in the clinical reasoning skills of novice and expert therapists than the quantitative measures used.
Practice differences in occupational therapy between Australia and the United States, due to different health care systems, may limit generalizability of these findings. The small sample size used in the study was also a limitation. The artificial use of head-mounted cameras and video recorders during therapy was another limitation of the study. This unusual approach may have influenced the therapeutic experience, since it could have been a distraction to both therapist and patient. These findings, which come from an inpatient physical rehabilitation setting, may not apply to occupational therapy practice in community settings.

Mitchell and Unsworth (2004) studied clinical reasoning in community health occupational therapists in Australia. The purposes of the study were to describe the work of community health occupational therapists and to obtain basic information regarding the clinical reasoning skills used by community health occupational therapists. A survey design was used to explore role perceptions and clinical reasoning skills of community health occupational therapists. Subjects for the study were 50 occupational therapists involved in the provision of home health occupational therapy in four metropolitan regions of Australia. Thirty-six of the surveyed subjects returned the completed survey, for a response rate of 72%. The respondents’ average length of practice was 12 years of practice; thus, they were considered expert practitioners.

Respondents were asked in the survey about the nature of their work responsibilities, about their self-efficacy beliefs regarding their work, and about factors that they perceived as supporting or detracting from the quality of their work. They were also given four paper-case scenarios of increasing clinical complexity and
asked to generate written solutions to the clinical problems presented. The data from
the case studies were analyzed qualitatively and quantitatively by first summarizing
the main issues or responses from each participant, coding the issues thematically,
and then determining the percentages of respondents who discussed each theme

The results suggested that the participants had confidence in their clinical
skills and considered client feedback (69%), communication skills (42%), and
knowledge of client conditions (33%) as important factors in guiding their clinical
decision making. Regarding the case scenarios, the researchers determined that the
participants used a variety of clinical-reasoning skills to guide their actions. Subjects
displayed decreasing levels of confidence in dealing with the increasingly complex
case studies.

Limitations of this study included the study design itself. The authors
concluded that utilizing a survey to examine the clinical-reasoning skills of therapists
did not produce sufficient information to answer their research questions. As a
dynamic and interactive process, clinical reasoning may be best studied using
phenomenological or ethnographic methods such as interviews and observations of
interactions between therapists and clients. Other limitations are related to the
differences between health systems in Australia and the United States, and the
limiting of the participants to a practice area of home health.

Gahnström-Strandqvist, Tham, and Josephsson (2000) examined client–
therapist interactions in the psychosocial rehabilitation process with occupational
therapists in Sweden. The participants were seven occupational therapists with 2 or
more years’ experience working in a psychosocial rehabilitation program, either a work-based or activity-based program. Data were collected in the form of narrative interviews, and participants were asked to recount one or two stories about their work with a client. Eleven narrative interviews were collected describing therapist interactions with clients having psychiatric disabilities.

The data were analyzed using a qualitative method called mimesis (Ricoeur, 1991). The first step in the mimesis process was prefiguration and involved reading and rereading the stories in an attempt to understand the setting and context. The second step, called configuration, involved understanding how the therapists’ actions related to problem situations. The third step, refuguration, was used to develop an understanding of the therapist’s actions and interactions with the clients.

Key themes that emerged during the analysis of the narrative were labeled creation in collaboration, emplotment, suspense, turnings, and therapeutic outcomes. Creation in collaboration refers to the context of the rehabilitation process and the ability of the therapists to create a safe, structured, and supportive setting for rehabilitation. Participants demonstrated this theme through adopting nonjudgmental attitudes toward the clients and supporting a tolerant, democratic therapeutic environment. Emplotment was demonstrated by the participants as they helped their clients tell their story and visualize possible solutions to problems. Suspense referred to the improved ability of the clients to handle the routine uncertainties of everyday life. The participants indicated their awareness that the process of recovering from mental illness can take many years and that clients need to set the pace. Turnings was the term used to describe the increased ability of the client to cope with a situation
after engaging in emplotment with the participant. The term *turnings* has been used in connection with life-history research and indicates a critical shift in perception on the part of the individual being studied. Therapeutic outcomes were characterized as clients being able to live or work more independently as a result of working over time with the participants.

The authors suggested that community-based occupational therapists need to create and maintain supportive contexts for rehabilitation in order to help clients envision a positive future. They also argued that occupational therapists must be willing to adopt multiple professional roles as needed to support their clients’ needs. Limitations of the study include the somewhat esoteric terms applied by the authors to the different themes identified, the limited sample, and the fact that the study was conducted in a country with a very different health care system than exists in the United States.

This section has examined key concepts of professional expertise, including the three types of knowledge that comprise professional expertise and the stage-specific way in which professional expertise is developed. Research has been reviewed about how occupational therapists develop professional expertise and clinical reasoning in institutional and community settings. The next section examines phenomenological research studies of the professional expertise of occupational therapists.

**Phenomenological Studies of Occupational Therapy Practice**

The aim of phenomenological research is to understand what an experience or phenomenon means for the persons who have had the experience (Moustakas, 1994).
Phenomenological research methods developed as a reaction to the logical positivism of behavioral psychology, which attempted to reduce all human experience to observed behavior, without consideration of personal meaning. Phenomenologists are interested in the meaning and structure of experience and in concepts of consciousness and intentionality. Phenomenologists do not assume to know the meaning of experiences for the people they are studying; rather, they are interested in the meaning that the individual ascribes to the experience (van Mannen, 1990).

Phenomenological approaches have been used to explore health, wellness, and occupational engagement from the perspective of the client and the practitioner in occupational therapy (Auerbach & Richardson, 2005; Padilla, 2003; Rosa & Hasselkus, 2005; Ward, 1996). Phenomenological research in occupational therapy is consistent with core beliefs of the profession about the centrality of the individual and his or her understanding and experience of disability and recovery (Wilding & Whiteford, 2005). Occupational therapists, like phenomenological researchers, are concerned with understanding the meaning of everyday activities of individuals in context. Phenomenological research in occupational therapy has often focused on the experiences of persons living with a disability (Auerbach & Richardson, 2005; Padilla, 2003). Some studies, however, have examined the experiences of occupational therapy practitioners (Rosa & Hasselkus, 2005, Ward, 1996, 2003).

Table 5 presents a comparison of several phenomenological studies reviewed in this section.

Rosa and Hasselkus (2005) used a phenomenological approach to examine the lived experiences of six novice and eight career occupational therapists in adult
rehabilitation settings. The purpose of the study was to gain an increased understanding how occupational therapists experience working together with patients over time. Participants were six novice (0-2 years’ experience) and eight career occupational therapists (5 or more years’ experience), recruited via purposive and snowball sampling procedures. Data were generated using phenomenological interviews and participant observation of patient–therapist dyads. Each participant was interviewed two times for approximately 2 hours per interview. The interviews were scheduled one to three weeks apart and were conducted at the therapists’ work settings. The researchers were present for all treatment sessions involving the participating therapist–patient dyad. These treatment sessions including daily morning sessions focused on personal care at patient’s bedsides and afternoon sessions in the clinic. Length of patient stays ranged from 8 to 21 days, with a range of 11-24 observed sessions per patient. The patients were not interviewed for the study.

Analysis was ongoing throughout the study and utilized a narrative approach, which involved considering the story as the unit of analysis. A story was defined for the study as a participant’s experience with a given patient. All the participants in the study described the therapy story as having a beginning, middle, and an end. The analysis began with a reading of the transcripts of all the interviews. Stories were examined for meaning units, or sections of adjoining text on the same topic (van Mannen, 1990).
<table>
<thead>
<tr>
<th>Author</th>
<th>Year</th>
<th>Subjects</th>
<th>Number of Participants</th>
<th>Novice</th>
<th>Expert</th>
<th>Data Collection Methods</th>
<th>Data Collected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daley</td>
<td>1999</td>
<td>Nurses</td>
<td>20: 10 Novice, 10 Expert</td>
<td>6-18 months’ experience, 15-34 years’ experience</td>
<td>1-2 hour interviews</td>
<td>Clinical narratives</td>
<td></td>
</tr>
<tr>
<td>Finlay</td>
<td>2001</td>
<td>OTs with 10+ years experience</td>
<td>12 NA</td>
<td>NA</td>
<td>NA</td>
<td>1½ hr interviews of nine subjects</td>
<td>3 subjects shadowed for 4 weeks</td>
</tr>
<tr>
<td>Gahnström-Strandqvist, et al.</td>
<td>2004</td>
<td>OTs with 2+ years experience</td>
<td>7 NA</td>
<td>NA</td>
<td>NA</td>
<td>2-3 interviews, 1-1/2 hours each 1 interview</td>
<td>Observation of patient-participant interactions</td>
</tr>
<tr>
<td>McMillan &amp; Rosa &amp; Hasselkus</td>
<td>2005</td>
<td>Nurses OTs</td>
<td>15 Six novice, eight expert OTs</td>
<td>1-2 years 0-2 years’ experience</td>
<td>NA 5 or more years’ experience</td>
<td>Two 1-2 hour interviews with each participant</td>
<td>Reflective journals</td>
</tr>
<tr>
<td>Tryssenaar &amp; Perkins</td>
<td>2001</td>
<td>OTs and PTs</td>
<td>Three OT students and three PT students</td>
<td>NA</td>
<td>NA</td>
<td>Video recording of patient session with participant</td>
<td>Participant comments on recorded session</td>
</tr>
<tr>
<td>Unsworth</td>
<td>2001</td>
<td>OTs</td>
<td>Five: three expert, two novice</td>
<td>Novice: less than 18 months experience</td>
<td>Expert: more than 5 years’ experience</td>
<td>Video recording of patient session with participant</td>
<td>Participant comments on recorded session</td>
</tr>
<tr>
<td>Ward</td>
<td>2003</td>
<td>OT</td>
<td>One</td>
<td>Expert: 25+ years’ experience</td>
<td>3-hour interview</td>
<td>One day of observation</td>
<td></td>
</tr>
</tbody>
</table>

**Table Summary:**
1. Range of study participants: 1-20; average, 9
2. Novice therapist definition range: 6 months to 2 years
3. Expert therapist definition range: 5-25 years
4. Interview range: 1-3 interviews, lasting 1-3 hours each
5. Observation range: 1 day to several weeks
Meaning units were then grouped into categories of experiences and by whether they referred to the beginning, the middle, or the end of the therapy story. The researchers described having a breakthrough in the data analysis process, which allowed them to discover the main story types of the narratives.

The three main story types discovered were those in which therapy generally went well from the beginning, those in which the therapists were able to work through challenges for a successful outcome, and those where they were unable to work through the challenges. One common theme emerged from the data for all participants. This was the theme of working together with patients to find a common ground of meaning. For the novice therapists in the study, doubt and uncertainty sometimes undermined their ability to find common ground with patients. Even experienced therapists reported challenges related to the interpersonal aspects of practice. The researchers concluded that occupational therapists should have strong interpersonal communication skills in order to negotiate effectively with clients. Therapists should not assume clients will always agree with them on therapeutic goals.

In a phenomenological study of expert occupational therapy practice, Ward (1996) interviewed and observed three therapists in community mental health settings over a period of several months. The purpose of this doctoral study was to describe the experience of community mental health practice through a qualitative study of occupational therapists in community settings. A secondary purpose was to demonstrate the value of occupational therapy services for people with serious mental illness. The participants in the study were a purposive sample of three occupational
therapists, each having at least 15 years of experience in the field. Ward chose participants who were good communicators with a strong commitment to their work and the ability to describe their work in a way that conveyed the meaning of their experiences.

Data were collected using interviews, observations, and artifact review. The interviews ranged in time from 2 hours to 2 days. One participant was interviewed by the researcher as they drove around to visit her community clients (Ward, 1996). One participant practiced in a day treatment program of a community mental health center, one was in private practice providing consultation to agencies, and one was transitioning from inpatient to community practice.

Data were analyzed using a method called bricolage. Bricolage is a complex, reflective, collage-like process that represents the researcher’s images, understanding, and interpretation of the world or phenomenon under analysis. Bricolage means to assemble odds and ends in making something (Patton, 2002). Ward felt that the bricolage method allowed her to immerse herself in all the facets of the community practice that she observed with her subjects and to reflect that immersion in her written data analysis.

Lengthy narrative case studies of each of the three therapists comprised the majority of the research findings. Themes common to all three therapists emerged from the data. These included the use of complex clinical reasoning skills and the need for occupational therapists to assume multiple professional roles such as consultant and case manager in the community settings. Ward concluded that occupational therapists have important skills to offer community mental health
clients. Clients with serious mental illness are not always well served by traditional verbal therapies, and often need training in practical daily living skills in order to become more independent. Expanding the scope of occupational therapy community practice and understanding the challenges of transitioning from hospital-based to community-based practice all merit further study.

Ward (2003) also studied the clinical reasoning processes of a single occupational therapist in a community setting in a separate study (2003). Her purpose was to examine the clinical reasoning processes used by the participant in a mental health setting. This case study used a single, 3-hour interview and a day of observation at the participant’s work site as the methods of data collection. During the day of observation, the participant was periodically asked to reflect on her work and her client interactions, and the responses were audio-taped. The subject was a purposively chosen occupational therapist with over 17 years of experience in community mental health.

Data were analyzed using a hermeneutic iterative process. Hermeneutic iterative processes involve reading and rereading the data in order to obtain a contextual understanding of how study participants interpret and make meaning of their experiences (Cohen, Kahn, & Steeves, 2000). Research findings were also compared to the literature in the field and discussed with professional colleagues. Ward presented initial findings to a panel of phenomenologists who were not occupational therapists in an attempt to triangulate her data analysis process. The goal of the data analysis process was to develop units of meaning and determine which
types of clinical reasoning skills, as defined by Mattingly and Fleming (1994), were being used by the participant.

Ward found the participant simultaneously used procedural and interactive reasoning as she led a community meeting with clients. The participant continually assessed all the clients regarding their mental status as she simultaneously worked to draw out reserved clients and calm agitated clients. She worked to create a safe environment for the clients through the narrative structure of the group process, and helped the clients set meaningful daily and weekly goals using procedural reasoning. The participant was also observed using simultaneous procedural, interactive, and conditional clinical-reasoning approaches in a task group. She used the group activity to help her clients develop problem-solving and frustration-tolerance skills, talking with them about how they could apply those skills to other areas of their lives. Effective interactive and procedural skills were needed to set up and run a group activity for persons with varying needs and varying levels of function. Ward speculated that interactive-reasoning skills may be especially critical for therapists in mental health practice. Interactive-reasoning skills may also be especially important for community-practicing occupational therapists, who may not rely on the structure of institutional practice to ensure patient cooperation. Instead, they have to create a meaningful relationship with the client, motivating the client to work in partnership with the therapist to achieve therapeutic goals.

Summary

This section reviewed existing conceptual literature on professional expertise in occupational therapy and related disciplines, and the use of phenomenological
research methods to study occupational therapy practitioners. Based on the literature reviewed, professional expertise is considered a critical aspect of professional practice and warrants further study.

Understanding professional expertise in occupational therapy practice is an ongoing line of inquiry. Although a few studies of professional expertise in institutionally based occupational therapists have been undertaken, research on the professional expertise of community-practicing occupational therapists is extremely limited. To date, no qualitative phenomenological studies of how community-practicing occupational therapists develop professional expertise have been undertaken. This study was designed to increase understanding of how occupational therapists develop professional expertise in community practice. A phenomenological approach that seeks to understand the experience from the perspective of the participants is well suited to the subject, since professional expertise is a broad and complex construct not easily subjected to quantitative analysis.
CHAPTER THREE

METHODOLOGY

Because the focus of the research study was on understanding the experience and meaning of professional expertise in community-practicing occupational therapists, a qualitative phenomenological design was used. Phenomenological research grew out of phenomenological philosophies and is used in diverse fields, including sociology, education, psychology, and occupational therapy. The goal of phenomenological research is to explore the meaning of the lived experience of individuals (Bogdan & Biklen, 2003; Moustakas, 1994; Van Mannen, 1990).

The chapter reviews basic concepts of phenomenology as a philosophical perspective, phenomenological research methods, and the role of the researcher. The specific rationale for this approach is discussed. This chapter also includes information on recruitment and protection of participants for the study, a description of the data collection and analysis process, the research time line, and limitations of the research.

Origins of Phenomenology

Phenomenology originated as a 20th century philosophical movement dedicated to describing experiences as they present themselves to consciousness (Van Manen, 1990). German philosopher Edmund Husserl is considered the founder of phenomenology. For Husserl, what was important was the study of the structures of human consciousness, free from the personal biases or presuppositions of the researcher. Meaning is viewed as personally constructed by individuals as they interact with others and interpret those interactions. The best way to understand the
meaning of an experience or phenomenon is through the words of the individuals experiencing the event. Husserl used the term essences to describe the core element of a phenomenon and was especially interested in the emotional experiences of individuals. A search for greater understanding of the human experience is an essential element of phenomenological philosophy (Van Mannen, 1990).

Martin Heidegger was another German philosopher, a pupil of Husserl, who extended and developed Husserl’s ideas into his own approach to phenomenology. Heidegger developed the concept of dasein, or being-in-the-world, which is meant to focus attention on the meaning of everyday experiences (Heidegger, 1982). Concepts of form, meaning, intentionality, choice, and consciousness are critical in phenomenology, and Heidegger believed that only through an examination of their actions could humans become fully aware of their intentions. Heidegger also recognized the broader social implications of phenomenology, stressing that a person’s cultural and social background is always implicitly present in his or her experience.

Phenomenological Research Methods

The application of phenomenological philosophies to the development of research methods has been challenging (Finlay, 1999). In the absence of directives from the originators of phenomenology, researchers have attempted to develop their own approaches to ensure the rigor of their studies, with varying results. Some researchers are challenged for using a reductionistic approach to data analysis that is overly simplistic (Wilding & Whiteford, 2005). Others are cited for a lack of rigor in their research design and analysis (Finlay, 1999). The original intention of
Phenomenological inquiry included trusting the findings to emerge almost intuitively from the data. Modern researchers attempt to strike a balance between description and analysis by using a variety of data analysis methods. These include reducing and categorizing the data, searching for common themes and meanings, and using quotes to introduce individual voices into the discussion of the data, especially to illustrate specific findings (Finlay, 1999).

Phenomenological research methods require direct contact with individuals who have experienced the phenomenon under study, the collection of data in naturalistic settings, data reduction and analysis, and a search for possible meanings in order to view the phenomena of study in a new light (Moustakas, 1994). The research methods seek to capture multiple points of view of individuals, examining aspects of their everyday life in a variety of meaningful contexts, and developing rich descriptions of their social world that are subjected to reflective analysis revealing underlying structures of the experience (Moustakas, 1994). For the study, all interviews and observations of participants, with one exception, took place in naturalistic settings in which the participants worked. This approach allowed for a more complete understanding of the phenomenon of study and was consistent with principles of qualitative phenomenological research.

Research Design

A phenomenological approach was chosen for the study because it provided a conceptual framework for understanding the experiences of the participants regarding professional expertise in community practice. The phenomenon of interest—community practice in occupational therapy—had not been studied in any great depth
when this study was proposed. Therefore, a phenomenological approach was used to generate broad findings upon which future research may be built. Phenomenological research methods are well suited to the study of health care and the experiences of health care professionals, as these methods examine how people interpret their lives and make meaning of their experiences (Cohen, Kahn, & Steeves, 2000).

Phenomenology as a research method was operationalized in this study through semistructured interviews and observations of the participants as they engaged in and reflected on the phenomenon of interest, community-based occupational therapy practice. Phenomenological methods were also used for the data analysis process, which involved reading and rereading the transcripts until themes emerged that were then clustered and compared to one another and to the literature on professional expertise.

The nature of qualitative research is such that the researcher becomes the instrument of research (Patton, 2002). As such, the credibility of the research depends largely on the competence of the person doing the research and the rigor with which the research is conducted. In phenomenological research, the researcher is presumed to have a personal interest in the subject of study. The researcher is seen as connected to the phenomenon, the subject and object are integrated, and the data of experience, including thinking, sensing, reflecting, and judging, are regarded as the primary evidences of scientific investigation (Moustakas, 1994). Like the originators of phenomenology, this researcher has a profound respect and appreciation for individual experience. To honor the experiences of the participants, I attempted to
question respectfully, listen attentively, and analyze carefully (van Mannen, 1990) throughout the data collection process.

As the researcher in this study, I brought my own background and interests to the process. I have been a registered and licensed occupational therapist for over 20 years. I am also an occupational therapy educator, chair of an academic occupational therapy program at a local university, and a doctoral candidate in education. I worked for over 10 years in hospital and community clinical settings serving individuals of all ages with chronic and acute mental illnesses and psychiatric disabilities. I have been actively involved at the local, state, and national level in leadership, practice, and policy initiatives, and have presented at the state and national level on effective strategies for occupational therapists interested in moving into community practice.

I became interested in the topic of community practice over the last several years through developing and teaching a course on community program development for occupational therapy students at a small liberal arts college in the San Francisco Bay Area. Most of the program graduates initially took jobs in institutional settings such as schools or hospitals upon graduation, but a significant number have subsequently moved into community practice on either a full-time or a part-time basis. Many of these individuals have experienced considerable challenges adjusting to the expectations and demands of community-based versus hospital-based practice. The present research study focus grew from a desire to learn more about the experiences of these community-practicing therapists, to promote community practice of occupational therapy, and to more effectively prepare new occupational therapists for community practice.
In the absence of standard approaches used in quantitative research to ensure researcher objectivity, methods such as epoche, bracketing, and reflexivity (Moustakas, 1994, Patton, 2002) are used. Epoche is a Greek word meaning to refrain from judgment (Moustakas, 1994). The researcher using the epoche method attempts to approach the phenomenon of study with a fresh perspective, free of preconceptions and biases, and focused only on what can be seen or described, without reference to past experiences. This is also sometimes referred to as bracketing. Bracketing requires the researcher to acknowledge, and then put aside, his or her biases, so that fresh insights can arise from the data. As the researcher for this study, it was critical for me to keep an open mind, refrain from judgment, and put aside any biases I had about professional expertise in community-based occupational therapy practice.

Reflexivity is another technique that helped me approach the research with integrity. Reflexivity requires the researcher to be self-questioning and attentive to the social, cultural, and political perspectives that may influence the researcher perspective as well as the perspectives of the research subjects. To be reflexive, researchers must constantly question themselves about what they know and how they know it. It is only through this constant process of self-reflection that the researcher begins to develop the ability to step outside of his or her preconceived ways of seeing and really view the subject of study with a fresh perspective (Patton, 2002). The qualitative researcher must be able to speak with confidence and credibility, giving authentic voice to the experiences of her subjects. For this research study, I attempted to listen carefully, record and transcribe all the interviews verbatim, and maintain an objective and unbiased approach through the data analysis process.
The focus of the interview and the observations was on collecting data related to the development of professional expertise in community-practicing occupational therapists. This was done by asking the participants a series of questions in a semistructured interview format and by observing them in an interaction with one or more clients when possible. See Table 5 for the interview guide.

Specifically, questions were asked to probe for evidence of formal, practical, and reflective knowledge, the three elements of professional expertise. Questions were also asked to probe for evidence of a variety of clinical-reasoning strategies. I was interested in understanding how these community-practicing occupational therapists viewed themselves in terms their level of expertise relative to their years of practice.

Seven out of the 10 participants were also observed for a single episode of time interacting with one or more clients. Notes from each observation were transcribed, as were transcripts from the first interview. A second telephone interview was then done with each participant. The purpose of the second interview was to obtain clarification as needed from issues discussed in the first interview and then to open the conversation up to a more informal exchange.

Recruitment of Participants

Because occupational therapists in community practice are few in number and are often difficult to track via standard processes such as professional association membership lists, both snowball and purposeful sampling methods were used to obtain study participants. Snowball sampling relies on referrals from initial participants to generate additional participants (Patton, 2002). This strategy was used
minimally, due to an initial positive response to other recruitment methods. The primary recruitment methods were as follows: request for research participants sent to all members the Psychiatric Occupational Therapy Action Coalition, placement of a notice requesting research participants in the May 2006 Occupational Therapy Association of California monthly newsletter, and posting of a request for research participation on the Home and Community Health Special Interest listserv of the American Occupational Therapy Association. When individuals expressed an interest in participating in the study, they were sent a research participant demographic sheet to complete and return.

Once a pool of potential participants was developed, purposive sampling was used to select individuals who were geographically accessible and deemed able to contribute to a better understanding of the phenomenon under study through their participation. Twenty potential participants who met the inclusion criteria were identified, 12 agreed to participate, and 10 ultimately participated in the study. An original area of interest for this study was novice-to-expert levels of professional expertise, as defined by Benner (1984). Consideration was given to recruiting equal numbers of novice and expert participants, but the small number of participants made this strategy unachievable. Table 7 summarizes the demographics of the research participants.
### Table 5. Initial Interview Questions

Introduction: “I am interviewing you today because I am interested in your experiences as an occupational therapist in community practice. I some questions I would like to ask you. If there are any questions that you do not feel comfortable answering or if there are other related topics you would like to discuss, or if you have any questions at any time, just let me know. How does that sound? OK, let’s begin.”

1. Tell me a little bit about your career as an OT and about your current position in this community practice setting. ? How long have you worked here? How do you like it? What kinds of thoughts and feelings come up for you when you think about your work here?

2. Tell me about where you worked before you came here. How was that?

3. How do you think community-based occupational therapy practice compares to hospital-based occupational therapy practice? How is it the same? How is it different?

4. Tell me what a typical day is like for you here. What excites you about working here?

5. What kinds of things help feel you are doing your job well? What kinds of knowledge and skills specifically help you do your job well?

6. Are there things that make you feel you are not doing your job as well as you would like to? What are they?

7. Tell me how you decide what to do with a given client or group of clients.

8. Tell me a story about a good experience you have had with a client recently.

9. Tell me a story about a bad experience you have had with a client recently.

10. What are the some of the most rewarding parts of your work?

11. What are some of the most difficult or challenging parts of your work?

12. What do you do when you encounter obstacles in your work?

13. Do you think about your work often? If so, how and when? How is that for you?

14. How well do you think your OT education prepared you for your current community practice position?

15. Where do you see yourself professionally in the future? In one year? Five years? Ten years? How is that for you?

16. Is there anything else you would like to ask me or tell me about your experience in community occupational therapy practice?
### Table 6. Second Interview Questions

1. Have any other thoughts or questions come up for you since we last spoke? If so, please share them with me.
2. How much of the job that you do now do you consider standard occupational therapy practice, such as evaluation planning, and intervention with individual clients or groups? How do you feel about these parts of your job?
3. What parts of your job would you categorize as not specifically OT-related? How do you feel about those parts of your job?
4. What is your current level of satisfaction with your job, on a scale of 1-10? Why?
5. What do you look forward to when coming to work? What do you not look forward to?
6. How do you define professional expertise in community practice?
7. How do you rate your level of professional expertise in community practice? Why?
8. If you supervise OT students, how is that for you? If you do not supervise OT students, why not?
9. Do you provide professional mentoring for any occupational therapists? If so, how is that? How did it come about?
10. Have you received professional mentoring from another occupational therapist? How is that? How did it come about?
11. What barriers, if any, do you think exist that inhibit the move of OT’s into community practice?
12. What personal characteristics have helped you be successful in your community practice?
13. How strong would you say your professional identity as an OT is on a scale of 1-10? Why?
14. What helps you maintain your OT identity?
15. If you identify more strongly with another profession, what is that profession? Why?
16. Do you have any other questions or comments for me?
Participants represented a range practice areas and years of professional experience. Of the 10 participants who were included in the study, eight were female and two were male. Their ages ranged from 27 to 63 years old. Years of practice in occupational therapy ranged from 2 to 42 years. Seven possessed bachelor’s-level degrees in occupational therapy, and three possessed master’s-level degrees. Four of the participants practiced in mental health, and four with persons having physical disabilities. Of the other participants, one worked with at-risk youth and young adults, and one worked with women in recovery from substance abuse. All participants, with one exception, practiced in the greater San Francisco Bay Area. Two worked for community mental health agencies, six for community nonprofit social service agencies, one for a for-profit rehabilitation company, and one was self-employed.

Selection criteria for participants were as follows: participants were working at least part-time in a community setting, had graduated from an accredited occupational therapy program, were currently licensed as occupational therapists in California, and affirmed that they were using occupational therapy knowledge and skills in their current position.

Protection of Human Subjects

All research participants signed an informed consent form assuring the confidentiality of their contributions. After the interviews were transcribed, all identifying information such as names or places of employment was removed. Tapes, transcripts, and field notes are being kept in a secure location. The research was approved for human subjects review at the University of San Francisco prior to implementation of the data collection process (IRB # 06-038). The clients of the
occupational therapists were observed, but not interviewed, and were assured of their confidentiality. As directed by the occupational therapists, and depending on the policies of the agency, clients were given an opportunity to sign an informed consent form, indicating their willingness to participate in the study.

Data Collection Methods and Procedures

The primary methods used for data collection were semistructured interviews and observations. Initial interviews were from 1 to 2 hours in length. The first interviews were conducted in July and August 2006. Second interviews were conducted from September through November 2006. Observations were usually conducted immediately before or after initial interviews with participants.

Interviews

For this study, a purposeful sample of 10 community-practicing occupational therapists were interviewed and observed to help answer the research questions. All 10 participants were interviewed twice, once in person and once over the telephone, with the exception of one participant who expressed a preference for both interviews to be done in person. The first interviews took place in a variety of settings chosen by the participants. The majority of the interviews took place in work settings, but two were conducted in participants’ homes, one was conducted in the researcher’s office, and one was conducted at a coffee shop. Second interviews were conducted over the phone, with one exception, as noted above. Initial interviews lasted from 60 to 90 minutes, and were audio-recorded and subsequently transcribed. All but two of the initial interviews and all second interviews were professionally transcribed.
Table 7. Research Participant Demographics

<table>
<thead>
<tr>
<th>Participant</th>
<th>Age</th>
<th>Gender</th>
<th>OT Degree</th>
<th>Other Degrees</th>
<th>Practice Area</th>
<th>Employment Setting</th>
<th>Yrs as OT</th>
<th>Yrs in Community Practice</th>
<th>Generation</th>
<th>Site of Observation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>63</td>
<td>F</td>
<td>MS</td>
<td>BS, OT</td>
<td>Mental health</td>
<td>County mental health</td>
<td>42</td>
<td>36</td>
<td>First</td>
<td>Day center</td>
</tr>
<tr>
<td>2.</td>
<td>36</td>
<td>M</td>
<td>MOT</td>
<td>BA, Eng</td>
<td>Assistive technology</td>
<td>Community nonprofit</td>
<td>7</td>
<td>7</td>
<td>Second</td>
<td>Client home</td>
</tr>
<tr>
<td>3.</td>
<td>50</td>
<td>F</td>
<td>BS</td>
<td></td>
<td>Physical disabilities</td>
<td>Self-employed</td>
<td>26</td>
<td>26</td>
<td>First</td>
<td>Assisted-living facility, board and care home</td>
</tr>
<tr>
<td>4.</td>
<td>32</td>
<td>M</td>
<td>BS</td>
<td></td>
<td>Mental health</td>
<td>Community nonprofit</td>
<td>2</td>
<td>2</td>
<td>Second</td>
<td>N/A</td>
</tr>
<tr>
<td>5.</td>
<td>57</td>
<td>F</td>
<td>BS</td>
<td></td>
<td>Mental health</td>
<td>County mental health</td>
<td>35</td>
<td>33</td>
<td>First</td>
<td>Office</td>
</tr>
<tr>
<td>6.</td>
<td>38</td>
<td>F</td>
<td>BS</td>
<td></td>
<td>Mental health</td>
<td>Community nonprofit</td>
<td>5</td>
<td>5</td>
<td>Second</td>
<td>N/A</td>
</tr>
<tr>
<td>7.</td>
<td>60</td>
<td>F</td>
<td>BS</td>
<td></td>
<td>Parents with disabilities</td>
<td>Community nonprofit</td>
<td>30</td>
<td>33</td>
<td>First</td>
<td>N/A</td>
</tr>
<tr>
<td>8.</td>
<td>27</td>
<td>F</td>
<td>BS</td>
<td></td>
<td>Children and adolescents</td>
<td>Community nonprofit</td>
<td>4</td>
<td>4</td>
<td>Second</td>
<td>Residential treatment center and school</td>
</tr>
<tr>
<td>9.</td>
<td>54</td>
<td>F</td>
<td>MS</td>
<td>BA, education</td>
<td>Women and families</td>
<td>Community nonprofit</td>
<td>14</td>
<td>13</td>
<td>Second</td>
<td>Office</td>
</tr>
<tr>
<td>10.</td>
<td>34</td>
<td>F</td>
<td>BS</td>
<td></td>
<td>Neurological rehabilitation</td>
<td>For-profit rehabilitation company</td>
<td>12</td>
<td>6</td>
<td>First</td>
<td>Client home</td>
</tr>
</tbody>
</table>
All interviews were conducted by the primary researcher at a place and time chosen by the participant. The purpose of interviews was to provide an opportunity for the participants to reflect on their experiences as occupational therapists in community practice and to collect data for analysis to help answer the research questions. All interviews were audio-taped. Notes were also taken during the interviews.

The phenomenological approach to interviewing is informal and interactive, using open-ended questions and allowing the interviewee to shape the process to some degree (Moustakas, 1994). Therefore, the interview questions listed in Table 5 were used as a guide to the process, not followed rigidly in strict order for each participant. The interview questions were reviewed by two expert community-practicing occupational therapists prior to their use in the study. Several suggestions were made to the wording and the order of the questions, which were used to modify the interview guides. During the second interview, follow-up questions were asked based on a preliminary review of the data from the first interview and the observation, if one was done.

Observations

Naturalistic observation of participants during an interaction with one or more clients was the second data collection method used in this study. Observation provides an opportunity to understand the social environment in which the participant experiences the phenomenon of study, an opportunity for the researcher to have direct experience of the phenomenon of study, and an opportunity for the researcher to witness first-hand interactions between participants and clients, observing any
nonverbal interactions that may occur. Observation also helps the researcher collect
data that may confirm or disconfirm what research participants say in interviews
(Patton, 2002). Observations can foster the development of the “thick and rich”
descriptions of phenomena that are seen as a hallmark of good qualitative research.

Observational methods are most frequently used in ethnographic studies, but
are also increasingly used in other types of qualitative research. Several of the
phenomenological studies reviewed for this study used both interviews and
observations to collect data (Finlay, 2001; Rosa & Hasselkus, 2005; Ward, 1996).
According to Tynjälä and others, professional expertise is often situationally
grounded (Tynjälä, 1999). Thus, naturalistic observations were deemed well suited
for this study of professional expertise.

During the actual data collection process it was sometimes difficult to arrange
for observations of participant–client interactions. Concerns of confidentiality were
raised, and logistical issues also developed. One participant had a client cancel a
meeting with her. Another participant told me after I had arrived at the interview that
she does not work directly with clients, so there was nothing for me to observe.

Ultimately, observations were made of seven of the 10 participants.
Observations lasted from 1 to 3 hours, and were done of the participant working with
an individual or group of individuals in a variety of settings, including clients’ homes,
a classroom, and a day center. Observation logs were transcribed and used as data for
analysis. Three participants were unable to arrange an observation within the time
constraints of this study. Asking about the observed interaction during subsequent
interviews with the participants created an opportunity for the participants to reflect
on their practice. Data collected through the observations also served to support,
enhance, or refute data from the interviews, a process known as triangulation (Patton,
2002).

During the observations, notes were taken using a modified version of a
format suggested by Creswell (1994), which prompts the observer to record both
descriptive and reflective observations. The descriptive notes focus on the content
observed and the reflective notes on the process of the observer, including reflections
on the activities and ideas for later thematic development. The focus of the
observations for the study was on the participants and their interactions with the
clients, specifically with regard to examples of professional expertise.

Data Analysis Procedures

Data analysis was done following a seven-step method developed by Cohen,
Kahn, and Steeves (2000) for use in hermeneutic phenomenological research. This
process involves the following steps: 1) listening and thinking about the meaning of
what is being said during interviews; 2) immersing oneself in the data through
reading over the data several times; 3) transforming or reducing the data through the
process of data coding and making decisions about the relevance of data; 4)
development and analysis of themes and searching for passages with similar themes;
5) further thematic identification and reduction through cutting up photocopies of the
transcribed interviews and observations and grouping into thematic categories; 6)
identification of exemplars, or textual data in the language of the informant that
captures the essential meaning of the themes; and 7) writing and rewriting, reviewing
field notes, and engaging in a process of critical reflection.
Data analysis and reduction began after the first set of interview notes were transcribed by a hired transcriptionist. The researcher performed an initial review of each written interview transcription for accuracy while listening to the tape-recorded interview. The researcher then read the transcript two times to get an overall feel for the interview or observation, making notes in her research journal to assist with bracketing and self-reflection. Data were then coded to facilitate analysis (Bogdan & Biklen, 2003). Within these larger coding categories, specific subcategories of codes emerged. Codes were then grouped together for data reduction purposes, and some codes were eliminated as tangential to the focus of the study. As each transcript was read, it was compared to the list of codes developed from the previous analysis, using a constant comparative method (Strauss & Corbin, 1998). Additional codes were developed as needed. Thirty-five codes that corresponded to the research questions were ultimately identified.

The codes were then examined for their relationship to the research questions, and themes began to emerge. Themes were then examined for relevance to the concept of professional expertise and shared with participants before or during the second interviews. This member-checking process was used to increase the trustworthiness of the data. Additional questions were asked as needed to gain further insight into their initial responses.

A summary of representative quotes and observations was made as a way to organize the data prior to reporting the findings. A representative sample of quotations and observations from all participants was included. Each participant was quoted a minimum of four times and a maximum of 12 times in chapter 4. Data were
also reviewed for disconfirming evidence as a way to present a balanced view of the phenomenon of study. While most findings were true for most participants, there were exceptions, which are noted and discussed in chapter 4.

After all the data were analyzed, a summary of the key findings and themes was sent to the participants via e-mail as an additional member check. Participants were asked to consider whether or not they felt the themes were an accurate representation of their experience. While most of the participants agreed with most of the themes, one or two had specific comments or differing perspectives, which were considered and integrated into the discussion of findings in chapters 4 and 5.

The data analysis is reported in chapter 4. Chapter 5 presents a discussion of the study findings as they relate to the literature on professional expertise and the community practice of occupational therapy and also discusses the implications of the findings for occupational therapy practice, education, and research. Specifically, the findings are compared to the current literature on the different types of knowledge that comprise professional expertise, the development of professional expertise, and clinical reasoning strategies used by occupational therapists and other health professionals. Textural descriptions and quotations (Moustakas, 1994) are included in chapter 4 to help illustrate the thoughts, feelings, and memories of the participants as they relate their experiences. Quotations were used to illustrate textural themes and to share the experiences of the participants in their own words.

In the early stages of the study design, consideration had been given to recruiting equal numbers of novice and expert therapists and to looking for any differences or similarities between these two groups. However, the small number of
the participants made this unworkable. As the data were reviewed, variations among participants were noted related to years in practice but also on other factors such as whether they started their professional careers in hospitals. Participants were therefore clustered into two groups for the initial data analysis. These two groups were dubbed “trailblazers” and “pioneers.” Table 8 summarizes characteristics of these two groups.

The first group of participants had been in occupational therapy practice 20 years or more, started their careers in medical-model settings, and tended to use more of a medical model of practice, including using standard approaches to treat individuals with specific medical diagnoses. These were characterized as “trailblazers.” The second group of participants, dubbed “pioneers,” had been in occupational therapy practice from 2 to 14 years, went into community-based occupational therapy practice straight from occupational therapy school, and used more of a social rehabilitation practice model.

In a social rehabilitation model of care, services that are nonmedical are often provided to help clients with disabilities live independently in the community. These can include vocational services, supported housing, and social and recreational programs (Scaffa, 2001). The implications of these findings will be discussed further in chapter 5. Because the responses by first- and second-generation participants were similar regarding most of the research questions, however, the subsequent data analysis considered all the participants as one group.
Pilot Study

A pilot test of the study was conducted in fall 2004. The study consisted of interviews and observations with three different occupational therapists working in community settings. Three broad research questions were asked: What is the experience of occupational therapists working in community settings? How do occupational therapists understand their experience of community practice? What factors influence the experiences of occupational therapists in community practice?

Data were collected from three participants at three different sites. At each site, the participant was asked the same set of interview questions with slight modifications as needed. At each site, interactions between the participant and one or more clients were observed. Observations lasted from 60 to 90 minutes.

Six common themes were ultimately identified: commitment to community practice, specialized skills and abilities needed for community practice, the use of varying types of clinical-reasoning skills, client-centered practice, the environmental context of community practice, and professional identity as an occupational therapist. All participants expressed positive feelings about the meaning and value of their work and all planned to stay in their current positions in the near future. Findings from the study confirmed that this is a useful area for further research, and helped this researcher focus on professional expertise as the organizing concept of the proposed study. Limitations of the pilot included the small sample size and the limited time available for interviewing and observing the participants, analyzing the data, and reporting the results.
Table 8. Characteristics of First- and Second-Generation Community-Practicing Occupational Therapists

<table>
<thead>
<tr>
<th>Generation</th>
<th>First</th>
<th>Second</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title</td>
<td>Trailblazers</td>
<td>Pioneers</td>
</tr>
<tr>
<td>Career Path</td>
<td>Started in hospital practice</td>
<td>Started in community practice</td>
</tr>
<tr>
<td>Years in Practice</td>
<td>25-26</td>
<td>2-14</td>
</tr>
<tr>
<td>Personal Characteristics</td>
<td>Resilient, adaptable, persistent, creative</td>
<td>Independent, passionate, motivated, creative</td>
</tr>
<tr>
<td>Typical Clinical-Reasoning Strategies</td>
<td>Interactive, conditional</td>
<td>Interactive, conditional</td>
</tr>
<tr>
<td>Student-Supervision</td>
<td>One out of five</td>
<td>Four out of five</td>
</tr>
<tr>
<td>Strengths</td>
<td>Surviving system change, content expertise, mentoring, networking</td>
<td></td>
</tr>
<tr>
<td>Challenges</td>
<td>Retirement, succession, burnout</td>
<td>Economic advancement and security, career laddering, isolation</td>
</tr>
<tr>
<td>Needs</td>
<td>Professional support and recognition, legacy opportunities, models of student supervision</td>
<td>Professional support and recognition, mentoring, relevant continuing education</td>
</tr>
</tbody>
</table>
CHAPTER FOUR

RESULTS

This study explored the perceptions of community-practicing occupational therapists about their professional expertise, using a qualitative, phenomenological approach. A purposeful sample of 10 community-practicing occupational therapists were interviewed and observed to help answer the research questions. Data were transcribed and reviewed twice with the participants, once before the second interview and once after key themes had been identified. Participants confirmed that the key themes accurately represented their experience as community-practicing occupational therapists.

The findings of the study are presented in this chapter and reported by research question. For each research question themes are identified and discussed. Themes are illustrated with key participant quotes and observations. Chapter 4 concludes with a summary of the themes and two participant narratives that serve to illustrate these themes.

Research Question 1

What constitutes professional expertise in community-practicing occupational therapists?

Four themes common to all participants emerged from the data to answer this question. These themes were commitment to community practice, commitment to client-centered practice, use of diverse creative approaches to help clients become more functional and independent in the community, and distinctive shared personal attributes.
The first theme was a clear commitment to the ideals and practice of occupational therapy in the community. Participants saw their work in the community as “authentic” occupational therapy, because they were helping clients achieve personally meaningful goals. Length of time in community practice for participants ranged from 2 to 36 years. Participants valued helping clients identify and accomplish personally meaningful life goals, including achieving and maintaining employment, living in the community, and being able to resume meaningful occupations. One participant worked in a community rehabilitation program for adults with head injuries and other neurological disorders:

It’s actually a really great environment to work in. It’s really an occupational therapist’s dream. It’s home and community-based, so that means we start off in the person’s home and then we take him out in the community. So we go to the grocery stores, the local coffee shop, Starbucks, the shopping malls. For my college kids, the library and things like that are our clinic settings. We go to the college and we sign them up for the disabled students’ program, get them into adapted physical education. We’ve taken people back to their workplace, we’ve talked about return to driving, we talk about how to get your license back from the DMV and so forth. I really, really enjoy this setting—it’s one of my passions. actually.

Another participant worked with women and families experiencing homelessness or recovering from substance abuse. She conceptualized the practical issues she worked on with clients as a way to help them feel empowered:

To me this is true occupational therapy, being in this environment—not to say that being in a hospital is not occupational therapy, but this is where I get to assist my clients with meeting the goals that they want . . . getting back out into the real world . . . doing the things that they want to do, whether it be going to school, getting a driver’s license, obtaining funding, obtaining housing, just working on all of those goals: working on their self-esteem, working on their self-awareness, making them a stronger person.

This same participant felt her work was congruent with her beliefs as a feminist:
Working with women and empowering women, I think it’s very important . . . they have so many opportunities open to them, but they are not aware of it. And I’m assisting them and facilitating them with gaining those skills and opportunities they need to go on and be strong and to support their families and go on with their lives. It’s very exciting for me.

Another participant, who worked with disabled parents, offered a different perspective. She felt privileged to have the opportunity to work with clients in their homes and in the community. She believes that community practice is better than hospital practice for the practitioner, as well as the client:

Because we don’t live in a bubble, the community piece is the one that really allows people to live their lives to the fullest. The community allows you to see their strengths. They give you a gift by allowing you into their home. You are seeing a piece of them that you don’t usually get to see.

Several participants who had previously worked in or completed internships in hospitals saw a clear difference between the structure and routine of hospital practice and the freedom and creativity of community practice. One participant stated, “in an institutional setting, everything is happening within the building, whereas in community-based practice, the sky is the limit.”

One participant, who owns her own business, however, showed me the room in her house where she does her billing, which also serves as the guest room. She said that while she values the flexibility of working for herself, it can be a problem at times when she is unable to leave her work or when she finds herself working long hours on evenings and weekends. She was aware that at times she shortchanges her family for her business.

Participants generally expressed a strong preference for community practice over hospital practice, and some participants actually held very negative views of
hospital-based occupational therapy practice. They saw hospital-based practice as
prescriptive, structured, and not always relevant to client goals:

I think OT in the hospital is very structured and routine. I remember one
session had to do with activities of daily living, and the other session was
somewhere in the gym or walking down the hall or going down to the local
gift shop or hospital gift shop. I think it’s very, very routine.

One participant described his experience in a skilled-nursing facility where he briefly
worked:

I did not like the work I did at a skilled nursing facility because it felt to me
more like damage-control occupational therapy . . . the Medi-Cal paperwork
was a nightmare. It was very standardized, and you had to justify everything
you did to get money from Medi-Cal, and that didn’t fit well with me. I had to
use very specific pointers and say, “This is what we’re doing, so please pay
us.” That money should be there. I didn’t feel you should have to beg Medi-
Cal for funds that should automatically be there to take care of the elderly in
their last years.

Another participant described a very negative experience in an institutional setting
early in her career:

My first job was in an institution for emotionally disturbed children. It was
just horrendous . . . it was tearing my heart out to see the children being in this
environment. They were institutionalized, cognitively impaired because of
their life circumstances. I don’t think I ever want to work in an institution
again.

Participants expressed a belief that community practice helps persons with
disabilities live lives of dignity and meaning. During observations made for this
study, the participants worked in client’s homes, in office buildings, and in a school.
Participants interacted with their clients in a respectful, relaxed, informal manner.
Sessions started and stopped when the clients’ goals were accomplished and were not
limited to an arbitrary amount of time, as is often the case in hospital settings. Session
lengths went from 20 minutes to 3 hours.
Some disconfirming evidence was found for this theme of preference for community practice, however. During the second interview with one participant, she told me that she has recently reduced her hours at her community-practice job and increased her hours at a local hospital. She said that she had recently been asked to take on more administrative tasks at the community job, which she did not want to do. Also, rather than working with teens and younger children, she was being asked to work with young adults, many of whom had committed serious crimes. She expressed concern for her personal safety: “I found I was putting myself in more danger than I was willing to—so that’s when I decided to self-evaluate. . . . I just felt like I did not want to deal with that.” This participant voiced a concern that differed from the majority of the participants, but one which may be important. If occupational therapists are asked assume responsibilities for which they feel unprepared, or to place themselves in possible danger, they may not be motivated to enter into or remain in community practice.

The second theme that emerged was a strong commitment to client-centered practice. Participants viewed their work as centered on helping clients determine and make progress toward self-selected goals. “I leave the decision about what to do to the client, because it’s their goals, not mine,” said one participant. This participant spoke at length about being drawn to community practice because it fit with his personal values and beliefs about letting people make their own choices in life:

The model we work with here is very client-driven. . . . I don’t think people do well with people telling them what to do . . . for me, what I like best is the focus on the client . . . it’s really asking the client, in what ways can we support you as you move through [the program], because these are your goals that you established when you came in here, so let’s review them.
Participants were clear that they valued and respected the client’s goals, and when families were available, they also involved them in the goal-setting process. One participant, who worked with older adults, put it this way: “My model has become to ask myself, ‘What would I do if this were my mother?’” This focus on client-centered practice was consistent with the stated personal values of the participants and seemed to be a factor in their decision to enter community practice: “I want them to tell me what they want to do, not me. I don’t want this power didactic, where I’m the professional and I’ll tell you what to do.”

Participants also recognized that their goals for treatment did not always match client goals, and that when these differed, the clients’ goals took precedence:

Clients are super-involved in goal-setting, so there are goals that sometimes I thought it was a good goal and but the client said, “I don’t really want to work on” and so we’ll just delete it or modify it. For example, I had this one guy who had a stroke and he could do all his basic self-care, with the exception of bathing. His wife was helping him out when he first came home, and each week, or every couple of weeks, I’d say, “How’s the shower going?” Because he didn’t want me to do it with him. And finally he said, “My wife does it for me, it’s good,” and so we just dropped that goal.

In observations, participants often started the session by asking the client what they wanted to work on that day. For example, one participant was working with a young female client who wanted to apply to college. The participant sat with the client at the computer and helped her through the process of completing the application online, requesting transcripts, and selecting possible courses in which to enroll. In another session, the client expressed a desire to be able to independently walk up and down a short flight of stairs in her home between her living room and her kitchen, so the participant worked with her on this task for part of the session. In a
third session, the occupational therapist worked with a client to develop expertise using her voice-recognition software and personal computer.

One participant, however, expressed frustration at not being able to provide truly individualized care to her clients. Because she worked part-time as a contract therapist for a school district, she was required to implement a treatment plan that was been developed by others and which she did not always think was appropriate or helpful:

A lot of times, I will be thinking, “This child can’t even hold a pencil, how are they going to write their name?” . . . Definitely, we have a lot we can do once we get the goals and the clients, but the set up of the treatment, we have no say in that.

Another participant has worked for a county mental health department for many years. The program where she provided direct services to clients closed, and she has worked on a variety of special projects over the last several years, including staff diversity-awareness training, continuing education workshops, and quality assurance. Although she was grateful to have a job that used her occupational therapy experience and perspective, she expressed frustration at no longer being able to work with clients.

The third theme related to research question 1 was that participants enjoyed using diverse and creative approaches to help their clients become more independent. While participants used standard occupational therapy interventions, such as assessments and individual and group treatment sessions, they also used individualized, community-based activities such as accompanying clients to job interviews and helping them register in person for college classes. In one observation, the participant ran a group that made gift wrapping, as a way to help clients develop
prevocational skills and also raise money for the program. Another participant created
a wall of sticky notes in bright pink with numbers on them, which were posted in the
client’s home. The goal was to help the client improve her visual tracking,
sequencing, and memory skills by reading the numbers out loud, and adding and
subtracting them. This participant, who had worked for several years in hospital
practice, told me that in hospital clinics, many standardized treatment protocols and
resources are available for therapists. In community settings, however, those
resources are not always available, and the therapists must therefore be more
resourceful and inventive.

The same participant was observed working with her client on biomechanical
tasks of static and dynamic balance and grip strength using nonfunctional, exercise-
oriented activities. When asked about this, she admitted that sometimes there is
professional role blurring at her agency and that some of what she does could be
viewed as physical therapy, which often focuses on muscle strength and coordination
outside the context of functional tasks. This role blurring may be an artifact of this
particular agency, but according to the literature, it also happens more frequently in
community settings (Dougherty, 1994).

Several participants identified the ability to perform standardized and
nonstandardized functional assessments as a valuable part of community practice.
One participant said: “Our assessments are looking at independent living skills. Can
they read a map? Get around the bus route to get to a job interview? Do they know
how to dress for an interview?” Several participants expressed the belief that
occupational therapists are well qualified in the area of functional evaluations, and commented that others on the treatment team expected them to provide this service.

Eight of the 10 participants were specifically helping clients with vocational issues. One participant’s job title is employment specialist, and her work was helping clients prepare for, secure, and maintain employment. Participants recognized and appreciated the value and meaning of work for their clients. They administered vocational assessments, counseled clients on how to get jobs, accompanied them to job interviews, and served as job coaches to help them improve their performance on the job. Participants expressed a sense of satisfaction at seeing their clients return to work. The participant who worked as an employment specialist stated, “What I always love to see is that once the person gets the job, it’s amazing to see how much of their life falls into place around it.” Another participant saw the desire to work as a universal human trait:

I like the universality of the desire to get back to work and engage in that role. Everyone has it who comes through here and I’ve seen it in effect. When people get work, their faces light up and they feel happy and that makes me feel happy.

Most of the participants also taught independent-living skills such as grooming, cooking, and shopping, and community-mobility skills to their clients and acknowledged that as a very important part of their work:

I guess the most rewarding thing is, I can just sit down and work with people and try to help them develop skills that they’ve kind of lost along the way or maybe they just need to revisit, you know. When they get it, and they come back to me, and they’re excited about it, that just gets me excited and happy.

Participants frequently listed management, community outreach, committee service, planning and implementing continuing education workshops, marketing,
budgeting, staff in-services, and other administrative tasks as part of their job responsibilities. While they were willing to do these extra jobs as needed, most participants felt that they should be recognized as having specific skills as occupational therapists and given the opportunity to contribute those skills to the program. As one participant stated: “The occupational therapy is the best part of my job . . . when I’m trying to help somebody learn a skill that makes them more independent, that’s my favorite.” Participants preferred to be seen as the functional specialist on the team, able to work with clients as needed and also provide training and consultation to others, rather than functioning as a generic case manager or clinician. They frequently expressed a desire to work more directly with clients rather than doing more administrative tasks.

Some participants had expertise in advanced practice areas, such as assistive technology, ergonomics, vocational rehabilitation, or parenting with a disability. Case management is a role often filled by occupational therapists in community practice (Cara & MacRae, 2004). The participants, however, had mixed feelings about case management. Some enjoyed working with clients on all aspects of their recovery, but others stated a preference to use occupational therapy–specific skills with clients and let other team members assume general case management functions.

The fourth theme that emerged was that participants viewed themselves as possessing distinctive personal attributes that helped them succeed in community practice. They saw themselves as outgoing, curious, adaptable, independent, creative, confident, motivated, dedicated, and self-directed. They appreciated the variety of
community practice and the fact that every day brought new challenges. As one
participant said:

One of the other things I like about community practice is that you can take a
very creative approach to working with your clients . . . so my tool bag is
extremely large, and I draw from so many different sources all the time, and
rarely does someone question what I’m doing. They see that what I’m doing
seems to work, and it’s accepted, so it’s not as rule-bound as institutional,
more institution-based settings. There really isn’t a standard protocol for
treatment here.

One participant reflected on how her own personality style helped in her work:

Extroversion helps . . . flexibility helps, my ability to change my counseling
style based on the client I’m working with. And my natural curiosity, because
I can find out a lot about the clients, because I’m just really interested to
know.

The ability to be flexible was reinforced in several observations. For example,
in one observation, the social worker arrived at the client’s home during the
occupational therapy session, and rather than have one or the other therapist leave, the
occupational therapist suggested that the social worker and she do a co-treatment. In
another observation, the occupational therapist was unable to modify a piece of
furniture for a client, so she found the resident handyman and gave him instructions
on what needed to be done.

Participants also frequently characterized themselves as persistent, optimistic,
and determined:

I just never give up on anyone; it takes a lot for me to give up on someone. Basically, I tend to just really keep going with people. I have a lot of personal
faith in people, as long as we’re on a track where I know that they want to do
this for themselves, I feel as though I can keep going with them. I tend to be
persistent in terms of getting stuff done; I just tend to be persistent.

Participants were very clear that community practice demands certain skills
and characteristics, and that occupational therapists who lack these characteristics
may not be happy or successful in community practice. Several participants stated
their belief that new occupational therapists need several years of experience before
they can be successful in some community-practice settings. One practitioner, who
has only been in the field for 2-1/2 years, said he is still developing professional
confidence. Another, who has been in the field for over 20 years, stated:

    I think that definitely this is not a job for a brand-new therapist. I think having
fundamental skills from inpatient and outpatient quite frankly helps me with
this job. I see new clinicians, like 3 years, 4 years out, try to do this job. And
it’s not that they don’t do a good job, but they’re somewhat confused
sometimes, and then I'll start talking about ideas with them and they’re like,
Oh yeah, I get it.

The ability to adapt quickly to changing circumstances was seen as important,
especially in community settings with no other therapists around to rely on. As one
participant said: “Being able to be flexible with this job is a plus . . . being able to not
get flustered when something difficult happens, being able to handle the unexpected
and the unforeseen.”

Participants described a strong capacity for self-directed learning. Self-
directed learning is characterized as goal-oriented, systematic, and based on the self-
identified needs of the learner (Knowles, 1975). Self-directed learning assumes that
learners' experiences are rich resources for learning, that individuals learn what is
required to perform life tasks, that an adult's natural orientation is task- or problem-
centered learning, and that self-directed learners are motivated by internal incentives
such as need for self-esteem, curiosity, desire to achieve, and satisfaction of
accomplishment (Heimstra, 1994).

Participants demonstrated their self-directed learning in a variety of ways.
They were motivated to stay current with professional knowledge in occupational
therapy and related practice areas, and identified self-directed learning as an essential element of professional expertise:

I think people should take advantage of any educational opportunities that come up, any workshops that come up, forums and discussions, and just anything that is available to them that they can afford, they should do. I just think it’s so important to continue your education.

Another participant, who has been in practice for over 30 years, stated her belief that she had a professional responsibility to keep up with current developments in the field:

I do think all occupational therapists should be doing professional reading; they should just make it part of their week, so that they know what’s coming along and so that they are ready when these issues come up in the workplace.

Participants regularly attended conferences and continuing education workshops, and read professional literature. They also acknowledged their limitations and reflected on strategies to further develop their knowledge and skills. One participant recently completed a graduate program in occupational therapy, and others were considering advanced degrees or certification programs.

I feel like the area I need to focus on more sometimes is getting to the research and finding out what’s supported out there. Also, the theoretical base, I would really like to solidify the theoretical base that I’m working from.

One participant, however, had a slightly different perspective on education. She believes that much knowledge already exists that is not being used effectively:

I only have a bachelor’s, and my mom keeps saying, “Bring your education up to speed, get your master’s, get your Ph.D.,” and I’m thinking, “Maybe I should go into research . . . maybe I should get more expertise in something.” But when it comes right down to it, there is far more knowledge out there than people are utilizing. I don’t really want to write another book, I don’t want to create more knowledge—I want to get what we know out to the client.
While this perspective does not constitute disconfirming evidence per se of self-directed learning, it does present a slightly different perspective, which is that it is the application rather than the mere acquisition of new knowledge which is critical to ongoing professional expertise.

To summarize the findings for research question 1, the participants in this study verbalized and demonstrated professional expertise through their strong commitment to community-based, client-centered occupational therapy practice, their ability to use a diverse and creative range of knowledge and skills to help their clients achieve functional goals, and their personal characteristics of creativity, independence, flexibility, and persistence, which motivated them to seek self-directed learning opportunities.

Research Question 2

What combination of formal, practical, and reflective knowledge is used by community-practicing occupational therapists?

While study participants used all three types of knowledge, they stressed that practical knowledge based on experiential learning was the most useful to them on a day-to-day basis and saw it as a critical element of their professional expertise. They identified student internships and early work experiences as very important in preparing them for community practice. Participants who completed community-based internships were significantly influenced by them in their subsequent decision to enter community practice. Several participants stated they wished they had been given more experiential learning opportunities earlier in their education:

I don’t know if there would be a way to really provide the context immediately, provide more observation for students while they’re learning . . .
send them to places so that they can observe more in clinical practice to get a more holistic idea or a better, a three-dimensional picture of what they’ll actually be doing.

Participants emphasized that much of their learning after graduation from school was self-directed. When learning needs arose, they actively sought out new information. One participant who worked with older adults became aware of the need to educate herself about older-driver safety:

The whole thing of evaluating older drivers, you know, I just spent a year or two researching and reading and conferencing—I became an expert in that. And then I haven’t looked back and I know things have changed, but I’ve got the basics, I know what I wanted to with that.

Another participant described the process of starting a new program:

In the mid-’80s, programs were expected to start developing vocational programs to try and get people into work. I was quite an active part of that and basically taught myself how to do it. I never did have any specific training, but I relied heavily on the research and written practice theory that was developed and published over the years. Those principles guided us in developing our program proposal and communicating it to others. Even now our program philosophy is taken from that material. During our initial years, I made frequent calls to staff at other similar programs to get an idea how they would handle certain problems.

Participants recognized the need to continue their professional development, not only to learn new skills but also to stay connected to their practice communities:

I always get excited when I go to occupational therapy trainings, just because I see so many professionals around me, people that have more experience than myself, people who seem to have their finger on the pulse more than I do.

One participant, however, was very clear in her opinion that professional expertise cannot be gained solely from experiential learning. This comment was offered during the member check of key themes, and represents a slightly divergent perspective:
I don't really think an occupational therapist or any other professional can just go out in the community and nose out how to practice in a trial-and-error way. There needs to be a clear practice framework in place before that can happen.

Supervising occupational therapy students was seen as another practical way to keep professional skills current: “Occupational therapy students bring new ideas, new creativity, fresh eyes, a fresh mind—you learn from them as much as they learn from you.” In two sites visited, occupational therapy student interns were preparing to lead client groups. Several participants expressed a desire to supervise occupational therapy students, but felt that they were unable to meet the requirements of current occupational therapy internship models, which require direct supervision of students for a specified number of hours each week.

Formal knowledge, generally categorized as knowledge gained from formal academic learning situations, was also valued by the participants as contributing to their professional expertise. Participants felt that their occupational therapy academic programs provided a useful general foundation for practice, and taught them to look at people from a holistic perspective, a core value in occupational therapy:

I feel that occupational therapists are taught to look at the whole person, so first of all we have an awareness of infant, child, all ages of the spectrum of human beings, and we are also trained to look at the skills, the strengths, that a person has, and try to build on those strengths.

Several participants mentioned that they appreciated having learned the general theoretical background of occupational therapy, human development through the life span, and the basic structure and function of the human body. They also valued the interpersonal skills they were taught as part of their occupational therapy education and the opportunity to appreciate the diversity of occupational therapy practice:
I think what occupational therapy school did was, it opened my eyes to the possibilities of occupational therapy . . . all the different settings. I didn’t really understand it until I got into school, and I didn’t know how much an occupational therapist can do.

Five participants graduated from occupational therapy programs 20 or more years ago. They acknowledged that the field of occupational therapy has changed significantly in the last 20 years and that what they learned in school is no longer necessarily best practice. They recognized that their knowledge has come from multiple sources over the years:

You know, it’s been over 30 years since I graduated. What you take in from education you assimilate. It’s like working in the environment—you can’t tease it out anymore. Once you make a stew it becomes your stew, it doesn’t matter whose recipe it is, and I think if you gave everyone the same recipe you’re still going to come up with something different.

What was still important to these experienced therapists was the unique perspective of occupational therapy, more than any specific knowledge:

Our education and training has always been wide ranged. We’re trying to find that specific thing that makes the person love life, and what is it then that you can build on? Is it their granddaughter? Is it their basketball? You’re going to do your project and to get them to stretch their arms or whatever, building on their love. What’s going to make them respond and want to come in and do the particular activities?

However, participants generally did not think that their educational programs should necessarily have taught them more specific skills for community practice:

When I came out of school, I felt as though if I wanted something, I just went out and got it. I did not feel it was the school’s responsibility to give us anything. One of the good things about working with a group like —— is that when you see something you really need, you have the resources to go out and get it.

Participants recognized that their formal education was not the end of their professional education, but merely the beginning: As one participant said: “I think my
education was outstanding; I think I learned much of what I needed to know to enter community practice, and the things that I didn’t learn are things that I had to learn by experience meeting the clients.”

One participant, however, thought that occupational therapy students were not being taught enough practical skills in school:

The students are coming here without grounding in crafts or handwork, or even simple things that you think they would know, like sewing on buttons or doing hems, or clothing repairs, they don’t know how to do it. Most of them know how to do laundry, but believe me, they don’t all know how to cook or teach crafts, and I believe that if they don’t know how to do an activity analysis of a craft, they will also not be able to do an activity analysis of activities of daily living.

She was also concerned that occupational therapy students do not have the necessary skills to help clients successfully transition to community living:

Sometimes, when you go out in the community and you're in somebody’s room you have to just do something basic, hang a picture, hang a calendar, know how to put a molly bolt in the wall . . . there’s a lot of stuff that occupational therapists used to know. They were the ones on the staff that knew how to do it.

Finally, reflective practice was used by the participants to solve practice problems, review decisions made, and modify their behavior in the future to improve their practice (Schon, 1983). All the participants reported and demonstrated actively reflecting on their work during working hours, both alone and with peers. Many of the participants were also clear, however, that that they tried not to dwell on their work or clients after hours:

In my first few years in community practice, I did find myself thinking about work a lot outside of work. Sometimes it would mean I couldn’t get to sleep at night, because I found myself reviewing my entire caseload in my head, and it was bad because obviously it was leading to burnout; I was thinking about it too much. Probably I did need to spend more time reflecting than I do now, because I was new, and I was trying things for the first time and needing to
reflect more. Now I’ve gotten to the point where unless I am finding it very pleasant, I don’t reflect on work when I not at work. I won’t let myself.

Participants were aware of the potential for professional burnout and have created boundaries between their work and personal lives:

With the clients we work with, they’re always on our mind—we all talk about that. As I’m driving home at night, I’m saying: “I wish I could just take them home with me, I wish I had one more bedroom I could share. Tomorrow, I’m going to call and see if they can give me some more resources for this person.” Or I’m thinking of the young woman trying to find homeless shelters. I think I’m going to try calling this person and maybe they can give me a few more resources. So definitely I do think about [work], but I also know that I’ve got to take care of myself first before I can take care of them.

Others cited confidentiality issues as limiting their ability to reflect on their work with others away from the workplace: “It’s hard for me because my family knows my clients, because we are community-based and we have family activities. I have to be careful what I talk about at home.” Some participants missed having other occupational therapists around:

It’s hard not to be able to talk to somebody. A lot of people are in my situation, they’re the only occupational therapists. I’ve been in places where there was a lot of support, and I feel like that is what I want. I want to have people around me, you know, that I can talk to. It’s tough to be by myself.

One participant felt especially isolated as an occupational therapist:

Being alone as an occupational therapist for the last 12 years, that’s a long time. I don’t feel I am growing any longer as a professional, because no one here is an occupational therapist, so they’re not giving me feedback that I am meeting occupational therapy expectations. It’s up to me personally to make sure that I’m doing the best I can to uphold those.

In conclusion, while the community-practicing occupational therapists who participated in this study used a combination of formal, practical, and reflective knowledge in their work, practical knowledge was identified by all participants as the most meaningful. This practical knowledge facilitated experiential learning and took
the form of internships and other clinical experiences during their school years, and on-the-job and self-directed learning throughout their career. They used reflective knowledge at work to improve their practice, and also relied on professional peers, co-workers, professional groups, and mentors to provide additional support for reflective practice. They actively sought out opportunities to develop their professional expertise through learning experiences such as conferences, workshops, and continuing education courses.

Research Question 3

Which types of clinical reasoning are used by community-practicing occupational therapists to develop and maintain professional expertise?

Participants used primarily two types of clinical reasoning. They used interactive-reasoning strategies to establish and maintain effective therapeutic relationships with clients, and they used conditional-reasoning strategies to help clients identify and solve problems of community living.

All participants emphasized the importance of developing positive therapeutic relationships with clients. Unlike in hospital and other institutional settings, where patients constitute a generally “captive audience,” clients in the community make a choice about whether or not to engage in treatment. Thus, it is critical for community-based therapists to have effective interpersonal skills in order to engage and maintain clients in treatment (Russinova, 1999). In all the observations, the participants were observed having strong and positive relationships with their clients. They were comfortable and friendly with them, familiar with their needs, and quickly able to establish rapport: As one participant stated:
I’ve developed a relationship with him, [the client], he comes in and he plays pool, and he’s getting to know some of the not-so-pathological people as the people on the streets. I got him permanent housing . . . he’s willing to accept help, and he’s reconnected with his family.

Starting with the assessment process, participants described asking open-ended questions, listening to the answers, and suggesting ways they can help the client: “It’s really trying to figure out what the client is telling me, and then I try to fit what skills and tools I have to that, and offer it to them.” One participant gauged his effectiveness by his ability to develop positive relationships with his clients, and used the relationships to help clients achieve their goals:

How do I know if I am being effective? One, if the person shows up consistently and is really interested in working on it. And two, if they come in and they’ve done the homework assignments. If they’re really engaged in the process, even halfway, I think that’s a sign of success.

The community-practicing occupational therapists interviewed for this study partnered with their clients through the use of interactive-reasoning strategies:

I guess the most rewarding thing is, I can just sit down and work with people and try to help them develop skills that they’ve kind of lost along the way or maybe they just need to revisit. When they get it, and they come back to me, and they’re excited about it, that just gets me excited and happy. Or when they get a job, when people get work, that’s one of the most exciting things. They come back and they say, “I got a job,” and you just see their face and they’re happy and you give them a high five and everything is great.

Interactive reasoning may be especially important in community practice because clients are often seen over a long period of time and a positive relationship with a therapist is essential to sustain the therapeutic process (Cara & MacRae, 2004). Sometimes these relationships are maintained over the telephone and at great distance, as in the case of one participant who counsels clients all over the country:

There is a young woman who is blind and has spina bifida, and she’s been calling me about techniques for putting her 2- or 3-year-old to bed. So I'll field
calls and then sometimes, I'll end up in this long-term relationship, giving it time to support her, doing right by her, her family, and her kids.

The focus on developing a positive working relationship with clients and families was noted during several of the observations. In one observation, the participant and the observer were welcomed into the home of the client by the client's adult daughter. The participant seemed to have a good relationship with both the client and the daughter, as evidenced by a casual conversational tone and an exchange of information from previous sessions. The therapist knew the names of all family members and even knew the name of the family dog. They talked about past visits and about progress made, and at the end of the session they all talked about taking a community outing the next time to a bead store, since that was a favorite hobby of the client, and it would be her birthday the following week.

In another observation, at the end of the treatment group, the participant asked a client about her plans for the rest of the day, and when she said she was going to the beach, offered to put sunscreen on her back. This same participant met with a client in her office and was able to persuade him to undertake a grooming activity he clearly did not want to do, mostly on what seemed to be the basis of a trusting relationship. Later, the participant told me about an incident with this client where she was able to persuade him to make changes in his behavior that would help him remain in his living situation. She attributed her ability to influence him to the fact that she has developed a positive, trusting relationship with him.

One exception to this reliance on interactive reasoning was a participant who was observed working with two severely emotionally disturbed children in a residential care setting, and represents some disconfirming evidence. As a visiting
occupational therapist, the participant seemed only superficially connected to the children, and her time with them was very limited. Most of it was spent on formal assessment. She later expressed some frustration with this part of her work, which required her to implement treatment after someone else completed an evaluation and developed a treatment plan.

Conditional reasoning involves helping clients adjust to life with a disability and focus on the accomplishment of specific goals (Mattingly & Fleming, 1994). Participants used conditional-reasoning strategies to help clients solve daily life problems and achieve objectives such as getting a job, improving parenting skills, or living independently. One participant, who worked as a job coach, described the approach she used when working with prospective employers:

With work, having a commonsense approach is usually the best approach, because oftentimes employers have a certain idea of how they want the job done, and I’m able to help people break the tasks down, do some task analysis and just help people by providing sensible advice.

For clients with chronic conditions, community practice is often focused on reducing the need for hospitalization (Scaffa, 2001). Reducing rates of hospitalization for persons with serious mental illness is also seen as a way to reduce costs. One participant stated that this was an expectation of her program:

The actual goal of this program is to reduce hospitalization. If you wanted to boil it down to the barest minimum, we try to have them integrated successfully into the community, make sure they have food, clothing, shelter, and that they take their medicines.

Much of the focus of community-based occupational therapy practice is educational—teaching or reteaching skills needed for independent living. As one participant put it: “We teach them independent-living skills, basically everything to
get them to be as self-sufficient as possible. We actually teach them the skills to get out on their own and don’t just give them the answers.”

Participants were clear that they helped the clients with their own priorities and goals, rather than setting goals for the client. One participant told a story of working with a client who was a police officer:

He got into a motorcycle accident and he really wanted to get back to work, where he had multiple distractions to deal with and had to think quickly. So he got his police radio, so we could hear everything that was going on. They were looking for a suspect in a tan car, wearing a white T-shirt, blue jeans, that kind of thing. So we put the radio on, and I had MTV on, because he loves MTV, and as they were telling us what the location was, I had him try to find it on the map, and then he looked for it on the map, and then I said, “Well, where are we compared to that? How are you going to get there?” And then I would even task him even more and say, “Now, what was the description of the person? What were they looking for?” And then we’d have to listen to the next one and then I’d go back and refer to the first one and so forth. So it was a lot of multitasking. So I’ll do things like that. You just have to get really creative.

Another participant described focusing her interventions on valued life activities versus component physical skills. She gave an example of a resident in a nursing home who developed a condition called foot drop. The family member wanted someone to help the resident overcome her foot drop, but after some discussion, the participant helped the family member see that perhaps a better goal was helping the resident with car transfers so they could go for a drive, which was of more value to both the resident and the family member.

Participants often stated that seeing clients achieve or make progress toward their goals was the best part of their work. One participant helped people with disabilities acquire and use adapted computer equipment and technologies.
being able to find the right piece of equipment for the client was a source of great satisfaction:

I plugged [the keyboard] in and I set it right in front of him, and what was great is that he didn’t have to reach for anything, it was right next to him, and he started typing, and it was the perfect fit, and I just thought, “Wow, that was amazing. It was everything he just needed.” . . . And now what happens is, no one has to put his arms anywhere, he just has to get into his wheelchair and everything is set up for him. He’s a tiny bit more independent, so I just thought, “Wow, that’s great.” . . . It was a very rewarding kind of situation.

One participant, however, expressed frustration that she worked in a system that requires clients to be discharged if they become too high-functioning. This often led to client decompensation and rehospitalization. She expressed wishing that more supports and services were available to maintain persons with disabilities in the community.

In conclusion, participants used interactive-reasoning strategies to establish therapeutic relationships with clients, keep clients engaged in treatment, work more effectively with client families, and help clients in times of crisis. They used conditional reasoning to evaluate client needs, both formally and informally, set realistic goals with clients, and implement a variety of creative and functional goal-oriented interventions.

Research Question 4

What factors support or inhibit the development of professional expertise in community practice?

Participants reported feeling an increased sense of professional efficacy when they were able see their clients achieve success, enjoy freedom and flexibility in the workplace, use their occupational therapy skills creatively, and feel supported and
acknowledged in the workplace. They also identified peer supports and mentors as instrumental in helping them develop professional expertise.

Seeing their clients succeed was a very positive factor. As one participant said: “I mean, what warms my heart the most is to get that phone call, and I say ‘Well, what you need?’ And I go from there. I love drawing that out from the patients.” Their sense of job satisfaction seemed in part to depend on how well were able to help clients achieve goals:

If I am making good progress with my clients, either getting close to landing the dream job, or having someone just get the job, and they’re really excited, I’m excited to go in and support them, be with them, and see what we can do next to enhance their life.

Job satisfaction varied for participants, depending on immediate circumstances. When asked about their overall job satisfaction on a scale of 1-10 in the second interview, most participants responded in the 7-10 range. However, one stated that her satisfaction varied from six to eight, depending on how successful she felt she was able to be at helping her clients find jobs. Another said her current level of job satisfaction is “about six or seven, because of these difficult clients. . . . I feel hopeless about working with them, because the thrust in their lives is completely devoted to drug-seeking.” Participants acknowledged that at times it was hard to feel they are being successful:

In this program, we measure success in baby steps, very, very small increments, because these are the people that are probably the sickest in the whole system, they’re recidivists, they keep recycling in and out of the hospital, and they usually display extremely poor judgment. They stop taking their medicine, they hook up with friends and relationships that are destructive to them, they have a difficult time with their personal supports in their lives, and they will do things that drive people away from them.
Most of the participants, however, had a very positive, optimistic attitude toward their work and their clients, despite some treatment failures:

I don’t think there’s ever been a client that I came across that I felt, I don’t want to work with this person. I’ve had some very challenging clients, I’ve seen clients come in yelling and threatening people; but I mean, I kind of jump into those situations and do some problem solving and I’ve never come across a situation like I don’t want to be here.

Workplace freedom and flexibility was another factor cited by all participants as highly valued and contributing to an overall sense of professional expertise. They generally felt trusted by their supervisors to use their time appropriately and productively. As one participant stated: “There is a lot of flexibility, we have a lot of autonomy, we get to make our own schedules, as long as the client needs are being met and clients are being seen.” Another participant, who helped persons with disabilities use adapted computers, stated:

I love that it [the agency] is small, that I know everybody, everyone’s friendly, I like that there’s some structure, but not so much structure that I feel like I’m being oppressed. The only stress I feel is my own internal stress, I want to get things done, I want to do things right. I can set my own guidelines about what’s important.

Participants experienced the freedom and flexibility of community practice as different from typical hospital practice. Part of that was believing they are more respected as professionals:

There’s just so much more freedom with the direction you take with the client, there an acceptance of that. Regulations don’t just come out of nowhere. In the hospital . . . there’s this invisible body that you never see that sends information to the team and you just have to accept it, whereas here if there’s something new, chances are there will be an explanation of exactly why it’s happening.
One participant, however, who owned her own community-based business, expressed concern that she never seems to be able to get her work done in a standard 40-hour workweek. This could be seen as a downside of self-employment.

Professional mentors were cited as very helpful by participants. These mentors, past and present, formal, and informal, modeled effective practice and provided participants with opportunities to problem-solve with a more experienced professional peer. Professional role models were significant for several of the participants, especially early in their careers:

My first job was in working for a woman in a very rural area who had a private practice and watching her make contacts in the community, identify what the needs were, and she would just assign us clients . . . kind of like a mother hen, she got several occupational therapists working in the community, who were in the community and couldn’t really get started. I never thought of it at the time but that’s kind of what I’m doing now.

Others were inspired by a mentor to develop skills that eventually led them to their community setting and area of expertise:

I got my first experience with an occupational therapist working with computers and assisted technology, and she ended up being kind of a mentor-friend to me. She was very inspirational.

Some sought mentors after they found themselves in a community setting where they felt they needed to consult with a more experienced individual:

I was just really impressed with my mentor as an occupational therapist, and her ability to jump in and immediately say, “OK, this is what needs doing.” She was very proactive, and she just has a very sharp mind . . . so I called her up one day and said, “Could you be my mentor?”

Participants suggested that occupational therapists considering entering community practice seek out a mentor:

On the education end, really say to that student, when you get out there, it’s in your best interest to go find a mentor as soon as possible. Make sure you have
other professionals you can consult with who have experience... whether it’s with a mentor or with a peer, have somebody that you can check in with and say, “This is how I think I’m progressing, what do you think?” As occupational therapists in community practice a lot of times we’re creating it ourselves, and it’s “How am I going to do this on my own?” especially if you’ve been in acute care settings and then you jump into community practice and you’re not experienced with that.

While acknowledging the influence of these early mentors and role models, participants also acknowledged a desire for ongoing mentoring. Even experienced therapists expressed this need. One participant, who founded and runs her own community-based rehabilitation company, said:

What I would love to have, when you’re asking what’s missing, is, I don’t have oversight, I would love to have a mentor. K. was my mentor in the past. I’ve met with her a couple times, and I’m thinking I may ask her to do that again. I am at that point, I kind of need to ask some people—do I grow or not grow the company?— and things like that. So I could use a mentor and some oversight.

Support and recognition from peers and supervisors in the workplace was another factor identified by participants as helping them feel effective and valued. As one participant stated: “We try to support each other because it’s such a difficult job. There are times when somebody has just accomplished something, and I just have this burst of good feeling.” They especially appreciated the support they received from other non–occupational therapy staff:

I really love the people I work with, I have a great team here, I mean, this is a very unusual place, I think, in that we have a team that gets along really, really well, and people are very professional but they’re also very personable at the same time.

Participants valued being given the opportunity to use their unique skills as occupational therapists:

Although there haven’t been a lot of occupational therapists around here over the years, there has always been an appreciation of the value of occupational
therapy, and co-workers will specifically seek my advice as an occupational therapist. Even though we may have the same job title, they understand that my background is different, and they’ll run an idea past me and I’ll be able to give them some feedback from an occupational therapy perspective.

Participants felt professionally inhibited when they were unable to help clients achieve their goals; when they did not feel recognized or rewarded for their work, either financially or emotionally; when they had to work in isolation from other occupational therapists; and when they were unable to access needed support.

Several of the participants spoke of their own low salaries relative to hospital-based occupational therapists, and expressed concerns about future advancement and economic security:

Not to be selfish . . . but salaries are important, to keep up, so it was definitely a little bit of a shock to get quite a comedown from what I earned at the hospital, but I feel like this is where I am needed, and this is where I want to be.

One of the participants, a published author and nationally recognized expert in her field with over 25 years of experience, stated:

At first, I didn’t care if I didn’t make much money. I worked in the schools when my daughter went to college and my extra money helped pay for her education. Because we were contract workers, I got three times as much money as the nonprofit agency. I have an acquaintance who doesn’t have a bachelor’s degree and works for the county and she earns 3 or 4 dollars more an hour than I do. It’s pretty dismal. And we can’t keep an occupational therapist. We have one because she was a student, an intern of mine, because she wanted to do the work and she loves it right now. But we know that it’s really horrible pay. I always wanted to write the state and say they’re keeping me in poverty because of what they pay the regional center. I mean, it’s really depressing.

While expressing concerns about salaries, the participants were also somewhat apologetic, as if they thought it was wrong to be identifying this as an issue:

I guess another challenging part is the reduced pay here. That’s challenging to me because I feel like what occupational therapists offer is worth a certain
amount of money—but that’s the lot you have when you work for a nonprofit, there’s only so much money available.

Even those participants who did not have salary concerns of their own acknowledged that this might be a barrier keeping other occupational therapists from entering or staying in community practice. While some participants expressed concerns about their current salaries, they also expressed a commitment to the work and were willing to compromise on their salary expectations, at least for the present:

Part of the downside of working for this fabulous agency is that it is so comfortable for me that I find myself thinking, “Wow, am I ever going to leave this place?” But the reality is that after 4 years I have topped out on the salary scale.

Another participant stated:

I feel like sometimes I’m very lucky . . . I get paid to do something I basically like to do. It’s always nice to be making more money, but, you know, I’m enjoying what I do; I’m enjoying my job a lot.

One participant, for whom occupational therapy is a second career, put it this way:

This is my second career, and I always said that I was going to love what I do and do what I love, so don’t tell my boss, but I would do this for free. The salary is secondary; to me, it’s getting out and really helping people.

Other economic issues, such as fewer available full-time positions for occupational therapists in community programs, the inability of community programs to tap into traditional medical-model government payment sources for occupational therapy services such as Medicare and Medi-Cal, and the general lack of stable funding for community-based nonprofits, were mentioned also as areas of concern. As one participant said: “Obviously, the number one challenge is probably money—we work on limited resources with what we’ve got, and we become very creative with
Another participant shared a slightly different, more business-oriented perspective on economic issues:

To succeed in community practice, number one, be client-centered, number two, be able to hear their story and be helpful to them. Identify what they need and how they’re going to get it. And number three, keep in mind that they have to pay for this. You can’t tell people, “I want to start a private practice; I want to put up grab bars.” Well, why would they come to you to put up a grab bar? If your skill is marketable, people will pay for it, but you have to keep in mind that people have to need it and be willing to pay for it.

Several participants identified the relative isolation of community-based occupational therapists as another negative factor. Occupational therapists often are working without other occupational therapists in community settings. Participants felt that hospital- and school-based occupational therapists did not fully understand or appreciate their work in the community. Several of the participants no longer attended occupational therapy conferences or belonged to professional occupational therapy organizations. They believed that most of the professional occupational therapy literature and continuing education courses were focused on teaching clinical skills and approaches for hospital practice. One participant emphasized that it takes a certain personality type to deal with the relative isolation of community practice. “That’s probably the downside of this job; it’s a little bit of isolation. But you just have to take the initiative . . . it really takes kind of a creative go-getter person to work in this setting.”

Participants believed there was a general lack of awareness about the value of occupational therapy in community programs. One participant was always asking herself what the needs were in her community and who might pay for her services:

Home health agencies could do much more in this area, to focus on function, get physicians to identify what is really bothering patients, and its function,
and we can do that, and we can market to that area. The other thing that occupational therapists really need to focus on is cognition. We are way missing the boat. Somebody else is going to grab that from us. Cognition encompasses everything. The whole issue of chronic disease is ripe for occupational therapists. I don't know why there are not more occupational therapists being used in Kaiser’s chronic disease program. Hospice could use more occupational therapists.

One participant stated, “All occupational therapists should be at least somewhat familiar with ergonomics and with computers, or we are going to lose out to somebody else.” Participants thought that occupational therapists should be actively creating community programs, not just working in them: “I think it’s so important that we have these little grassroots community programs, these little storefront programs, that’s the way this began. Start small, explore grants, start more of these programs.”

Finally, several participants cited decreased client motivation and family issues as occasional barriers to effective community practice. Participants recognized that unless clients were motivated, they would not engage in treatment and could not be easily compelled to do so, unlike patients in hospital settings. Families sometimes became overinvolved in treatment, had unrealistic expectations of therapy, or hindered the therapeutic process because of underlying family dynamics. As one participant said:

I think that one of the difficult things is that when we go into people’s homes, we are basically on their turf, we’re in their domain, and whether we like it or not, we are stuck in the family dynamics, we are stuck into relationships, tensions, good ones, bad ones, all that kind of stuff. . . . Sometimes the room is filled with tension and then we do what we can.

In summary, participants identified seeing clients achieve their goals, workplace flexibility, positive early internship and work experiences, and peer
support and mentoring as facilitating factors in the professional expertise of community-based occupational therapists. Factors that inhibited a sense of efficacy in professional practice for participants included not being able to help clients achieve goals, decreased salaries and opportunities for advancement, a lack of support and recognition from within the occupational therapy profession, and a lack of awareness about their work outside of occupational therapy. Other inhibiting factors noted were client motivation and family dynamics.

Conclusion

The study examined the professional expertise of community-practicing occupational therapists, using semistructured interviews and observations. Data were analyzed following a seven-step method developed by Cohen, Kahn, and Steeves (2000) for use in hermeneutic phenomenological research. Themes emerged from the data that related to a variety of elements comprising professional expertise. Participants identified several elements as critical to their work as community-practicing occupational therapists. These included a deep commitment to client-centered care in the community and the use of a variety of clinical-reasoning and innovative intervention strategies to help their clients. Participants also expressed significant concerns about salaries and advancement, and wanted to receive more recognition and support for their work from their professional peers.

The community-practicing occupational therapists in this study characterized themselves as having a set of personal traits that have been useful to them. These included independence, motivation, initiative, maturity, persistence, creativity, and flexibility. They emphasized that occupational therapists considering entering
community practice need to have or develop these traits. The findings suggest that occupational therapists who thrive in community-practice settings are independent self-starters, who see themselves as capable and able to achieve self-directed learning goals.

While participants described using formal, practical, and reflective knowledge in their work, they relied primarily on practical knowledge on a day-to-day basis, but were also confident in their ability to seek out and use resources as needed to learn new skills. Although they felt they had received a good general education in their academic occupational therapy programs, they were less reliant generally on formal knowledge. This was especially true for those participants who graduated from occupational therapy school 20 or more years ago.

All participants reported using significant amounts of self-directed learning strategies. They attended conferences, stayed current with the professional literature, and attended continuing education workshops to maintain and improve their skills. Participants also consulted with peers and mentors as needed to learn new intervention strategies and techniques, especially when new practice areas emerged. Several of the participants used professional mentors to help them in their work. Most participants verbalized confidence in their ability to access information as needed for work skills development. This strong aptitude for self-directed learning might be a critical factor in the professional expertise of successful community-based occupational therapists.

Participants used active reflection to understand and improve their practice and determine the best course of action. They used professional peers and colleagues
to reflect on clients and cases, and generally felt supported in their decision-making process by their peers. Many participants choose not to think about work after hours in order to avoid burnout, preserve client confidentiality, and maintain balance in their life.

Factors that facilitated community practice for the participants were being able to practice creatively, feel acknowledged and supported, and see clients achieve success. Factors that inhibited community practice for the participants were not being able to help clients achieve their goals, connect with professional peers regularly, or be recognized and rewarded for their work.

While most of the findings were true for most of the participants, there was some disconfirming evidence, which was presented throughout this chapter (Patton, 2002). The disconfirming evidence presented here is interesting for what it implies about the challenges of community-based occupational therapy practice.

The first case was a participant who had worked in a community mental health program for 33 years. The program had closed several years ago, and the participant had been reassigned to a variety of nonclinical responsibilities, including quality control and cultural competency training for the staff. She did not think it was likely that another occupational therapist would be hired when she retired, because of staffing cuts, a reorganization in the delivery of services to community nonprofit agencies, and a lack of appreciation for the skills that occupational therapists can provide for persons with serious mental illness. She seemed somewhat discouraged about her own ability to demonstrate professional expertise as an occupational therapist, given these constraints.
The second case was of a younger occupational therapist who had only been in the field for four years. At the first interview, she was very positive about community practice and her work. At the second interview, however, which was conducted about 4 months later, she was less positive. She had recently cut her hours at the community site to increase her hours at a hospital setting. She gave two reasons for this change. One was financial—she was getting paid better at the hospital. The other had to do with job satisfaction and feelings of effectiveness, both critical factors in professional expertise (Yielder, 2004). The community agency where she was working had recently started working with forensic adults, and she did not feel equipped emotionally or professionally to deal with this population. She shared concerns about her personal safety and challenges to her own beliefs in being asked to treat persons who had been convicted of serious crimes.

Both of these disconfirming cases have implications for the future of community-based occupational therapy practice. As publicly funded health care systems change and evolve, it will be important for occupational therapists to be part of the planning for new systems of care. Otherwise, they may not be included as eligible health care professionals. Occupational therapy educators also need to better educate occupational therapy students to work with forensic and other difficult populations, if they are to feel ready for community practice. Finally, wage parity issues between hospital and community practice need to be addressed before any significant numbers of occupational therapists will enter into and remain in community practice.
Participant Narratives

This section concludes with two participant narratives. Phenomenological research concerns itself with the narrative nature of experience for individuals (Moustakas, 1994). A standard phenomenological approach to eliciting narrative experiential data is to ask the participant to “tell me a story about” the phenomenon of interest. For this study, participants were asked to tell a story about a client with whom they felt they had been successful, as well as a client with whom they had been less successful. Presented here are two of these participant narratives, selected for their usefulness in illustrating themes that were summarized in the previous section.

When asked to relate an unsuccessful client experience, this participant became thoughtful and reflective. She was clearly troubled by her inability to help her client achieve her goals. She expressed disappointment and discouragement at these failures, but was also able to be somewhat philosophical about her limitations. In the narrative that follows, the participant described her frustration at being unable to maintain a therapeutic connection with her client, but also acknowledged the limits of her resources. She commented on the difficulty of working with clients in relative isolation and how that sometimes negatively impacted treatment outcomes:

I’m thinking of a client who in some ways presents herself very well to a potential employer and who has a pretty good looking resume and good communication skills, is able to get her foot in the door, but once she is on the job it is harder for her to maintain her employment, because of outside life factors and lack of support. She’s in a category where she not eligible for case management, she doesn’t want to have therapy, and she refuses any kind of drug-and-alcohol recovery services, so it’s just little old me helping her out, and although I can make some impact, it was just too overwhelming. We have lost contact at this time. I haven’t called her in a while, she hasn’t called me in a while, because she’s able to pick up some work with her family, enough to stay afloat, but it’s not her dream job. It’s working with her family and there are interpersonal conflicts there, and it is sort of the default job. I always
wished that I could somehow help her understand that she needed more support. I didn’t feel effective enough to help her do everything that I felt she needed to do . . . and you know, I think for myself where I failed is that I felt hopeless and I really stopped working hard on her case because I just felt like we weren’t going anywhere because of her inability to accept other supports, so I felt like I was banging my head up against the wall. Every time we get ready for something, big, other things would occur in her life that would thwart our efforts and there weren’t people for us to have a treatment planning conference with because it was just me. It was frustrating, disempowering, and discouraging—it’s hard when you can see the potential in someone and yet you know that they are not living up to their potential, that’s hard for me.

When asked to relate a successful client episode, all participants were easily able to recall positive examples. Participants described feeling a deep sense of satisfaction at these outcomes and being inspired to continue their work. In the narrative that follows, the participant described working with a cowboy and helping him return to his daily life occupations of riding, roping, and going on trail rides after a traumatic brain injury. He was also able to resume parenting roles, including playing with his son. As the participant told this story, she was obviously pleased that she had been able to work effectively with this individual and clearly enjoyed recalling the treatment episode. She directed him in the natural setting where he worked and lived and adapted her treatment as needed to help him succeed.

Subsequent analysis of the narrative revealed that the participant used interactive reasoning to develop a positive relationship with the client throughout her treatment, used conditional reasoning and a variety of creative approaches to help the client achieve his goals, demonstrated self-efficacy traits of persistence and optimism, and worked effectively with other professionals on the team. She talked about the therapy as being “fun,” and was clearly invested in helping the client achieve his goals:
The most recent one was this guy who, he’s a young guy, he’s in his 30s. He was a real cowboy, he gathered cattle and everything, so our setting was the ranch, because that’s where he worked, and he lived on the ranch as well. He had [sustained] a head injury—how he got injured was that he was riding his horse, his horse got stuck in one of those squirrel holes on the ground and his horse went down and his foot was caught in the stirrups and he got dragged a couple of feet. So physically he was doing pretty good. He had some residual back pain, knee pain, and I think his shoulder may have been [hurt]—the rotator cuff may have been torn or something from the accident. Our first job was just to get him to think about sequencing, problem solving, planning—the basics. Our goals from the beginning were pretty minimal. He wanted to be able to work on his lassoing, because he had the cattle, so we had to work on that. He also had a little boy, a 2- or 3-year-old boy, he wanted to be able to play with him and not get a headache. So those were our initial goals, just building up his endurance in general, so we did a lot of physical activity on the ranch because it’s such uneven surfaces. We did a lot of running, jumping, hopping, skipping, throwing the ball, he did a lot of rope tricks that way. And then he got to the point when he felt like he was ready to get back on the horse and to go out and try to gather herd with his employer. So he did that, and unfortunately the first time it was unsuccessful—he had a massive severe headache, he had vision problems—and so we had to go back to the drawing board and break down what he did and he couldn’t do and so forth. We worked on the vision and similar stuff that we didn’t know would have come up because it wasn’t until he got on the horse and then he was on such an uneven terrain and going up and down constantly for the 2 or 3 days that he was out there, that finally his symptoms came up. So we worked on that, and then we worked on building up his mental endurance, just for being able to take in information about planning out his trip and being able to foresee things that might go wrong with the cattle or his horse. We worked for another 2 or 3 months, perhaps, and then he got back to work full time. And he was fine! He had a little bit of residual back pain but, you know, he did really well, So, to prepare for getting back to more stimulation, the favorite thing that the physical therapist and I did, we were in a corral, with our client on a horse, and the physical therapist and I were like his calves, so we were running around the corral while he was trying to lasso us. He’d get one of us and then the other one would kind of run up and then run away from him, so he’d have to get on his horse and run toward us, too. That was fun—that was definitely a lot of fun.
CHAPTER FIVE
SUMMARY, LIMITATIONS, DISCUSSION, IMPLICATIONS

Chapter 5 begins with a summary of the problem and purpose for this study, then discusses the findings of this study of the professional expertise of community-practicing occupational therapists. A comparison of the findings to existing research in this area is done, areas of convergence and divergence with the literature are noted, and the implications of the study for occupational therapy practice, education, and research are presented.

Health care is a major social issue in the United States today. With health care costs increasing rapidly, models of health care that focus on keeping people well are becoming more prevalent. One approach to reducing health care costs is community-based care that focuses on wellness, health promotion, and health education. For older persons and persons with disabilities, community-based care is also more affordable and desirable, as it allows people to remain independent, live in their own homes, and pursue meaningful occupations such as work. Persons 65 years of age and older are the fastest growing segment of the population today, use two to three times more health services than younger people, and need support to remain independent in their homes and out of institutional care (United States Department of Health and Human Services, 2004).

Given this shift to community-based models of care, health professionals need professional expertise in the provision of community-based services (Dassler, 1984; Grady, 1995; Loukas, 2000; Pew Health Commissions, 1991). Occupational therapists are licensed health professionals who work with persons having chronic
and disabling conditions. Occupational therapists promote optimal function, helping their clients live and work independently. Occupational therapy leaders envision a future in which health care is community-based and uses wellness and health promotion strategies (AOTA, 2005). Therefore, occupational therapists should be practicing in community settings. However, the majority of occupational therapists currently practice in institutional settings such as hospitals, following a biomedical model of practice. Very little research has been undertaken to study occupational therapists in community practice. Therefore, the study was undertaken. The focus of the study was on the participants’ experience of professional expertise in community practice.

Professional expertise is the ability to perform professional tasks and functions at a consistently high level of quality and effectiveness. Professional expertise is a multifaceted construct and has been studied in the fields of adult education, health care, psychology, and professional development. Professionals use formal, professional, and reflective knowledge, (Tynjälä, 1999), and also use clinical-reasoning strategies and interpersonal skills to help them achieve their professional goals.

Community-based occupational therapy practice differs from institutionally based occupational therapy practice in several important ways. Community programs offer support for independent living, provide a variety of nonmedical services, and are funded by nonmedical sources. Occupational therapists in community settings generally have freedom to plan and implement what they consider appropriate interventions for clients. They often work with clients, family members, and other
community agencies to provide client-centered care. Hospital-based occupational therapists generally practice in a more hierarchical setting, use a more biomedical approach to treatment, and follow standard diagnostically related treatment protocols.

Because of these differences between institutional and community-occupational therapy practice, professional expertise between these groups may also vary. To date, however, minimal research has been conducted of occupational therapists in community-practice settings. Therefore, this study of the professional expertise of community-practicing occupational therapists was undertaken, using a qualitative, phenomenological research design.

The study sought to answer the following broad questions: What is the experience of professional expertise in community practice for occupational therapists? How much do community-practicing occupational therapists use and value formal, practical, and reflective knowledge? What types of clinical reasoning are used most prevalently by community-practicing occupational therapists, and why? What factors are perceived as supporting or inhibiting community-practicing occupational therapists in their work?

The study used a qualitative phenomenological method to examine the professional expertise of 10 community-practicing occupational therapists. Participants had experience in occupational therapy ranging from 2 to 42 years and were recruited from a range of practice areas. All participants were interviewed two times, and seven of the participants were also observed in interactions with one or more clients. Data were analyzed by reading and rereading the transcripts, coding the data, searching for themes, reviewing and revising the themes, considering
disconfirming evidence, and performing member checks with participants to confirm that their experiences were being accurately represented. Quotations and observations reports were selected that could help represent the themes.

Data were reviewed for disconfirming evidence as a way to present a balanced view of the phenomenon of study (Patton, 2002). This evidence was noted and discussed by research question in chapter 4. Member checks were accomplished in two ways: When participants were contacted for the second interview, emerging themes were orally reviewed with them and their responses were incorporated into subsequent data analysis. After all the data were analyzed, a written summary of the key findings and themes was sent to the participants via e-mail, and they were asked to consider whether or not they felt the themes were an accurate representation of their experience. Most participants indicated general agreement with the findings. Some made some specific comments and suggestions, which were incorporated into the results section of chapter 4 and the discussion section of this chapter.

The themes that emerged from the data sometimes overlapped but generally created a picture of a professional with a deep commitment to community practice, a client-centered approach to care, a wide range of knowledge and skills that they creatively applied to help clients solve problems of everyday living, and a strong sense of self-efficacy. Study participants used interactive- and conditional-reasoning skills to develop relationships with clients and help them solve problems related to independent living. They relied primarily on experiential and self-directed learning to gain needed skills, but also use formal learning opportunities and mentors when available. While they felt supported by their professional peers in the workplace, and
were significantly motivated by client success to persist in their work, they also had concerns about advancement, recognition, salaries, and isolation in the workplace.

The study has significance because in the future growing numbers of occupational therapists may be practicing in the community (AOTA, 2005). Understanding more about the phenomenon of professional expertise in community-practicing occupational therapists may help support the growth and development of the profession in community settings, assist occupational therapy educators to design appropriate educational experiences and fieldwork placements for community practice, and provide useful information for occupational therapists considering entering community practice, so they may better understand and prepare for their chosen practice setting.

Limitations

Limitations resulted from two areas: limitations related to the nature of qualitative research and limitations related to researcher subjectivity. Since the purpose of this exploratory study was to examine a phenomenon of interest from the perspective of the individuals experiencing the phenomenon, it was not possible to generalize from the sample population to a larger population. However, the findings may indicate certain patterns or trends worthy of future study. Researcher subjectivity was addressed in chapter 3.

The fact that institutionally based occupational therapists were not studied to provide their perspective on professional expertise could also be considered a limitation to the study design. Participants all practiced in California, and all but one
practiced in Northern California. The experiences of community-practicing occupational therapists in other parts of the country may differ.

Participant ages, genders, and ethnicities varied, but the majority were Caucasian females. Minorities such as African-Americans and Hispanics were not represented. All participants worked primarily with adult populations, which could be considered another limitation. Participants who work with primarily children might have offered different perspectives. Another limitation is that the study was carried out by a single researcher. Thus, opportunities for review of interpretations with another researcher did not exist. This may decrease the credibility of the findings.

Discussion

Seven key themes emerged from this study regarding the professional expertise of community-practicing occupational therapists: 1) participants are strongly committed to the ideals and goals of community practice, and prefer community practice over hospital practice; 2) participants are strongly committed to client-centered, client-directed practice, and work with clients to identify meaningful goals for intervention; 3) participants use diverse and creative approaches to help clients become more functional and independent in the community; 4) participants possess strong self-efficacy traits, such as independence, creativity, perseverance, and self-confidence, which they believe help them be successful in their practice; 5) participants rely significantly on self-directed and experiential-learning strategies to develop and improve knowledge and skills for community practice; 6) participants value reflection as a way to deepen and improve their practice (however, participants also limit thinking about clients when away from work as a strategy to maintain a
positive work-life balance); 7) participants use interactive reasoning to establish and maintain effective therapeutic relationships with clients and conditional reasoning to identify and solve problems of community living.

Two overarching and contrasting themes could be seen as summarizing the experience of professional expertise for these community-practicing occupational therapists: 1) Community-practicing occupational therapists feel an increased sense of professional expertise when they are able to practice creatively, feel acknowledged and supported for their work, and help clients achieve their goals. 2) Community-practicing occupational therapists feel a decreased sense of professional expertise when they are isolated from their professional peers, are not able to help clients achieve their goals, and feel unrewarded and unacknowledged for their work.

The community-practicing occupational therapists who participated in this study demonstrate and describe their professional expertise in a variety of ways. First, they verbalize a deep commitment to and preference for community-based occupational therapy practice. There is a strong positive emotional component to their responses, indicating a genuine concordance between their work and their personal values. Participants see the community as the best place to provide meaningful interventions that can help people achieve and maintain independence. They actively sought out their current positions and are willing to make financial sacrifices to stay in community practice. They are very clear about the difference between hospital- and community-based occupational therapy practice and see hospital-based practice as overly constrained by reimbursement, productivity, and documentation requirements.
These findings were consistent with previous studies on community-based occupational therapy (Lemorie & Paul, 2001; Lewicki, et al., 1999), which suggested that individuals who thrive in community settings understand and appreciate the unique opportunities presented in this practice arena. In these studies, participants expressed a high level of satisfaction with community practice, despite some frustrations. Participants in the current study were also clear about their personal and professional commitment to client-centered practice. Client-centered practice has been identified as an essential aspect of community-based practice in a study by Lemorie and Paul (2001), yet almost 50% of the survey respondents in that study felt they had been unprepared by their professional programs for this approach.

All the community-practicing occupational therapists who participated in the study identified themselves as having personal characteristics that have been helpful to them. These include independence, creativity, persistence, motivation, flexibility, and adaptability. They also characterized themselves as self-directed learners, able to identify what they need to learn, access necessary resources, and accomplish their learning goals independently. They expressed confidence in their ability to learn what they need to in order to be effective on the job. These characteristics are similar to those cited by Fazio (2000) and Scaffa (2001) as helpful for occupational therapists in community practice.

These characteristics are also found in people with high self-efficacy traits, according to Bandura (1997). Persons with high self-efficacy are confident, creative problem solvers who enjoy new challenges and cope successfully with unforeseen situations (Bandura, 1997). They are optimistic, motivated, engaged, and able to
successfully overcome challenges through a process known as *enactive mastery*. Enactive mastery experiences occur when people are given opportunities to overcome obstacles through perseverance, and thus learn that persistence often leads to success. Occupational therapists in community settings often have to overcome significant challenges to succeed in their work. While it cannot be determined from this study whether persons with high self-efficacy traits are drawn to community practice or whether they develop these traits as a result of overcoming obstacles to achieve success, it does seem that persons having high self-efficacy traits may be more successful in community-practice settings than those with low self-efficacy traits.

Participants reported a significant reliance on practical and experiential learning in their day-to-day work. They identified the most meaningful part of their occupational therapy education as their clinical and internship experiences, which they categorize as experiential learning. They felt these experiences gave them the best preparation for practice, and helped them to consolidate all they had learned through more formal classroom situations. Participants identified self-directed learning as their primary method of learning new skills. These findings were consistent with studies of expertise in occupational therapists and other professionals, which emphasize the importance of situated and experiential learning (Brown & Duguid, 1989; Daley 1999). Estringer and Hildebrand (1995), in their study of counselors’ transition from novice to expert levels of practice, found that expert counselors used experiential learning and metacognitive strategies to solve ill-structured problems, such as those that often arise in community practice.
According to the literature, professionals with high levels of professional expertise take an entrepreneurial approach to their own career development (Van der Heijden, 2002). They identify their learning needs and goals, and constantly seek out new learning. Participants in this study described many ways in which they seek out new learning, including continuing education workshops and professional peer-support groups, and mentoring. Mentoring was mentioned by several of the participants as a means by which they develop their professional expertise. Mentors provide positive professional role models, an opportunity for informal problem solving, and general professional support for the participants. Those participants without mentors expressed a desire for mentoring, suggesting that more formal mentoring programs might help support community practice.

Participants described and demonstrated an ability to actively reflect on their practice to solve clinical problems and develop new strategies. Participants valued the opportunity to consult with occupational therapy and non–occupational therapy professional colleagues. This reliance on reflective knowledge is recognized as a critical component of professional expertise (Schoen, 1983). Several participants, however, have made a conscious decision not to reflect on work or individual clients when not at work. They use time away from work to rest, refresh, and avoid burnout. One participant also expressed concerns about client confidentiality as a limitation to her ability to talk about her work with others.

Participants used interactive reasoning to develop and maintain positive relationships with clients and families. Positive therapeutic relationships are especially important in community settings, where clients have a choice whether or
not to engage in treatment. The participants in this study reported and were observed using their interactive skills to negotiate with clients, provide them with a sense of hope, keep them engaged in treatment, and persuade them to do things they might otherwise be reluctant to try, like maintaining a medication regimen, applying for a job, or going back to work after a head injury. For persons with psychiatric disabilities, a supportive relationship with a care provider who can provide a sense of hope is an especially critical aspect the recovery process (Russinova, 1999).

Conditional reasoning focuses on trying to understand the meaning of the disability or the condition to the client, and help him or her re-engage in valued activities (Mattingly & Fleming, 1994). Participants described and demonstrated the use of conditional reasoning to help clients to determine appropriate goals for treatment or intervention. They described a wide variety of approaches used to help clients return to work, live independently, and regain functional skills, including taking community outings, playing games, riding a horse, enrolling for a college course, making gift wrapping, practicing wheelchair transfers, adapting a computer keyboard, and applying for a job.

Community-practicing occupational therapists may rely more on conditional reasoning because there are often no standard treatment protocols to follow, as in hospital practice. In hospital practice, procedural reasoning is heavily used, which applies a biomedical model to identify problems and treat areas of dysfunction in the person. Community-based practice focuses on community reintegration and skills for community living, while hospital-based practice focuses on stabilizing acute symptoms, teaching or reteaching basic client self-care skills, and preparing for
discharge. To some degree, the inherent differences in treatment settings could also account for the predominant types of clinical reasoning skills used in each setting.

The participants in the study cited several factors that they feel positively facilitate their community practice. The first factor is their experience of community-based occupational therapy as a positive, supportive, flexible work environment that encourages them to use all their knowledge and skills creatively. Participants valued the opportunity to develop creative interventions, take responsibility for their own schedules, and enjoy a flexible and relaxed work environment. These findings were consistent with studies that show occupational therapists have opportunities to develop and expand their professional roles in new and rewarding ways (Adams, 1991) and are expected to have strong generalist skills (Chalmers, Bramadat, & Andrusyszyn, 1998; Dougherty, 1994; Lemorie & Paul, 2001) in community settings.

Support and recognition from peers and supervisors in the workplace also helped participants feel valued and affirmed their sense of professional expertise. They described deriving satisfaction from working together with their colleagues to solve individual client problems and meet the goals of the agency or program. A review of the literature on community-practicing occupational therapists did not uncover any studies specifically examining motivation for entering community practice. This might be a good area for further research. It might also be important to look at ways in which traditional settings where occupational therapy is delivered can be restructured to provide some of the flexibility and opportunities for creativity that are more typical of community settings.
Several participants credited their decision to enter community practice to early community-based internships and work experiences. This is consistent with studies showing that student internship experiences have a significant influence over future practice decisions (Bossers, Cook, Polatajko, & Laine, 1997; Lewicki, et al., 1999). Interestingly, half of the participants currently supervise occupational therapy students, although most cited their own fieldwork experiences as an important influence on their later decision to enter community practice. Second-generation occupational therapists in this study supervised students more frequently than first-generation occupational therapists. Perhaps this is because the second-generation occupational therapists have been students more recently themselves. Clearly, there is a need for occupational therapy educators and community-practicing occupational therapists to work together to develop effective models of occupational therapy student education in community settings.

Participants also cited factors that inhibited their sense of professional effectiveness and expertise. Participants felt discouraged at times by low salaries, especially in community-based nonprofit agencies. They believed that their knowledge and skills were of sufficient value to warrant higher salaries and more advancement opportunities. One participant had recently increased her hours in a hospital setting, partly because of the better salary. Participants also sometimes felt a sense of isolation in community practice, and felt unrecognized and undervalued within the profession of occupational therapy. They disliked having to constantly advocate for occupational therapy to other professionals at their agency. These factors have been mentioned in the literature as significant barriers to the expansion of

Implications

The study used a phenomenological approach to study the perceptions of community-practicing occupational therapists regarding their professional expertise. Findings could be used as a foundation for research seeking to develop a formal theory of how community-practicing occupational therapists develop professional expertise, perhaps using a grounded-theory approach (Strauss & Corbin, 1998). A study of the professional expertise of institution-based occupational therapy practitioners might also yield interesting results, especially when compared to the findings of the present study.

Participants came from a variety of settings: nonprofit and for-profit, county agencies and proprietary businesses. Additionally, this study looked at occupational therapists working with a variety of populations: adults with serious mental illness, older adults, persons with physical disabilities, and persons experiencing homelessness or coping with substance abuse. Further studies could focus on one type of client or one type of practice setting. A challenge to this research would be the small numbers of community-practicing occupational therapists available in any one geographic area; however, this challenge could be overcome by conducting telephone interviews, having the participants keep time diaries, or using a survey methodology.

Research could also focus on how the professional expertise of community-practicing occupational therapists with and without mentors differs, and whether the perceived self-efficacy of community-practicing occupational therapists differs from
that of institutionally practicing occupational therapists. Another study could focus on perceptions of clients served by community-practicing occupational therapists regarding their professional expertise. Studies that document the cost-effectiveness of occupational therapy services in helping people return to work, secure and maintain housing, or avoid rehospitalization would support an increased role for occupational therapists in community settings.

Results of this study suggest several areas of focus for professional practice. First, community-practicing occupational therapists need to create and maintain professional support networks to lessen their feelings of isolation and increase opportunities for reflective practice and ongoing professional development. Professional associations such as the American Occupational Therapy Association can help through the establishment of a special-interest section for community-practicing occupational therapists, creating an online listserv to facilitate communication between geographically disparate community-practicing occupational therapists, and supporting community-practicing occupational therapists to present at conferences and publish in professional journals.

Another area of need is the establishment of formal and informal mentoring programs and networks to help newer as well as established community-practicing occupational therapists continue to develop their knowledge, skill, and professional expertise. Recently, state and national certification organizations have begun to recognize participation in mentoring relationships as a valid form of professional development. No formal guidelines currently exist, however, to structure and facilitate this process. The Occupational Therapy Association of California publishes
a directory indicating the practice setting of its members, but the national association does not. If this information were more easily available, community-practicing occupational therapists around the country and the world could more easily connect with one another. The ability to identify and connect with professional colleagues around the country and around the world is an essential element of professional practice and facilitates the development of professional expertise.

National and state occupational therapy associations also need to work with other professional associations and state and federal governmental regulatory agencies to address wage disparities between hospital and community practice. Until and unless this is done, occupational therapists will not move into community practice in any significant numbers. Other health professions have developed programs of tuition forgiveness in exchange for the student’s pledge to work a period of time with underserved communities and populations. This model could also be used in occupational therapy. Scholarships and stipends for students choosing to enter community practice should also be established. Federal training grants for students choosing to enter community practice should be sought.

Experts in community practice should be recognized and celebrated for their expertise, so they may serve as role models for the next generation. They should be recruited to publish and present at conferences and to teach and lecture at academic occupational therapy programs. This will become especially critical in the next decade, as the baby-boom generation of occupational therapists moves toward retirement and society’s need for occupational therapists increases. National health initiatives such as Healthcare 2020 call for increasing numbers of health professionals
trained in community-practice models of health promotion and prevention to meet these social needs (Institute for the Future, 2003).

Because community-practicing occupational therapists do not work in hospital or academic settings, they often have limited access to academic databases with current research in the field. Occupational therapy educators could develop partnerships with these clinicians, perhaps in exchange for teaching or supervising students, that would allow them access to academic databases through the university. This would support community-based occupational therapists to develop and maintain strong evidence-based practice and help and build campus-community partnerships, which are seen as critical in the health care professions (Community-Campus Partnership for Health, 2006).

While occupational therapy educators have already made many curricular changes to promote the development of community practice skills in their students, more remains to be done. Occupational therapy educators can promote awareness of community practice by inviting community-based occupational therapists to lecture and present in their programs and creating meaningful and effective community-based fieldwork opportunities. Occupational therapy educators can facilitate the development of client-centered practice skills by creating opportunities for students to develop effective interviewing skills, active-listening skills, and collaborative treatment-planning skills. They can recruit persons with disabilities to come and talk to students about their lives, values, goals, and needs before students enter clinical practice settings where the disparate roles of “patient” and “therapist” become more firmly established.
Occupational therapy educators preparing students to enter community practice need to help them develop creative approaches to intervention, versus teaching them standardized cookbook interventions. This can be done through assignments that challenge students to develop diverse and creative interventions for clients with a variety of diagnoses, disabilities, and conditions; by requiring that students consider both community-based and clinic-based approaches; and by including families in the intervention plan. Assignments that send students into actual community settings to interview persons living with disabilities and observe occupational therapists in community practice will also assist in the development of flexible, creative, adaptable therapists.

To promote self-efficacy in occupational therapy students, educators can provide opportunities for enactive mastery processes through a variety of teaching approaches, including problem-based learning, situated learning, and cooperative learning (Johnson & Johnson, 2000; Lave & Wenger, 1991; Scaffa & Wooster, 2004). Many occupational therapy programs already require students to learn community program development skills (Scaffa, 2001; Scott, 1999), and this should be a required part of all occupational therapy programs.

Occupational therapy educators can also examine the placement of their internship and fieldwork classes, and consider ways in which these can be integrated throughout the curriculum, rather than only at the end. In this way, they may promote increased situated learning and cognitive apprenticeships (Lave & Wenger, 1991). Some participants in this study suggest that all occupational therapy students should be required to complete a community-based fieldwork.
Occupational therapy educators need to work with occupational therapists in community practice to design effective fieldwork experiences for students. The traditional model of a 12-week, full-time fieldwork placement in one site needs to be expanded to include nontraditional models where the occupational therapist may only work part time, or may work in multiple community sites. Without meaningful community-based fieldwork experiences, few students will choose to enter this area of practice, as fieldwork experiences have been shown to have a significant effect on future career decisions (Lewicki et al., 1999). Some occupational therapy academic programs are experimenting with these models (Borcherding & Baldwin, 2001; Scott, 1999); however, more support from the Accreditation Council for Occupational Therapy Education (ACOTE) and national and state occupational therapy professional associations could help increase opportunities for community-based fieldwork.

Several of the participants suggested that academic occupational therapy preparations programs need to provide more experiential learning opportunities, earlier in the program. Occupational therapy programs have begun to incorporate experiential learning strategies into their programs (Scaffa, 2000; Scott, 2000), but more should be done to teach occupational therapy students how to engage in lifelong practical and self-directed learning after graduation. Having students create their own professional development plans and creating more opportunities for problem-based learning are educational strategies that can assist with this goal.

Helping students develop the skills to learn in uncertain situations through self-directed learning may also better prepare them for community practice.
Opportunities for occupational therapy students to grapple with complex practice problems can be provided through increasingly complex case study assignments, community fieldwork placements, and community program development assignments. Reflective elements can be added to all assignments to help students develop clinical-reasoning and reflective-practice skills. According to Schön (1983), reflective practice is a critical element of professional expertise.

Interdisciplinary health professions student teams can also be established to teach students to work together with other professionals in community settings. For example, at Dominican University of California, occupational therapy and nursing students and faculty are working together to design and deliver health and wellness services to older adults in community settings as part of a program called The Umbrella Project (I. Sheets, personal communication, November 2006).

Creating scholarships, stipends, and tuition-forgiveness programs for occupational therapy students with an interest in community practice could help ease the financial burdens of new occupational therapy graduates. When occupational therapy students graduate from private colleges and universities with significant outstanding student loans, they are often forced to seek employment where salaries are highest, which may not be a community-based nonprofit agency. Working with community-based nonprofits to develop new occupational therapy positions and partnering academic occupational therapy programs with community nonprofits in a faculty-practice model have also been shown to be effective ways to increase community-based occupational therapy practice (Walens, Helfrich, Aviles, & Horita, 2001).
The study was undertaken in an effort to better understand the experiences of community-based occupational therapists. Occupational therapy practitioners, researchers, and educators need to work together to support and develop community-based occupational therapy practice, remove barriers to effective community practice, and further facilitate the professional development of community-practicing occupational therapists.
REFERENCES


Community-Campus Partnerships for Health Web site: http://www.ccph.org


Kemp, C. (2003). Community health nursing education: Where are we going and how to get there? *Nursing Education Perspectives, 24* (3), 144-152.


APPENDIX A

Letter of Introduction to Potential Participants

Date

Dear Occupational Therapist,

   My name is Ruth Ramsey, and I am an occupational therapist and a doctoral student in the School of Education at the University of San Francisco. I am conducting a study on the experiences of occupational therapists working in community settings. I am interested in the professional development of community practicing occupational therapists (OT’s), and how they decide what to do with their clients.

   I am asking you to participate because I have reason to believe you may be an occupational therapist practicing in a community setting. Your experiences will be very helpful in gaining a better understanding of what community practice is like in occupational therapy. The results of this study could be used to develop ways to better educate OT’s for community practice, and to support OT’s already engaged in community practice.

   If you agree to be in this study, you will participate in two one-hour, in person interviews about your practice experiences. These will be conducted and audio taped by myself. You will also be observed for approximately one hour during a client-therapist interaction. All observations will be conducted in the settings where these naturally occur, and the interviews may be conducted at a setting of your choosing. If travel is involved for you, you will be reimbursed for any travel expenses incurred.

   If you are interested in participating, please return the enclosed letter of interest in the enclosed envelope, fax it to me at (415) 458-3774, call me at (415) 933-9034 (h), (415) 257-1393 (w), or email me at rramsey@dominican.edu. If you have any further questions that might help you determine whether you wish to participate in this study, please do not hesitate to contact me. Thank you for your consideration of my request. I look forward to having the opportunity to work with you.

Sincerely,

Ruth Ramsey, MS, OTR/L
Doctoral Student
University of San Francisco
APPENDIX B

Letter of Interest From Potential Participants

Ruth Ramsey
558-12th Avenue
San Francisco, CA, 94118

Dear Ruth Ramsey,

I am interested in participating in your study on community practicing occupational therapists. Please contact me to set up times for the interview and observation.

Name__________________________________________________________

Name of Agency/Facility___________________________________________

Best time to call___________________________________________________

Primary Phone Number______________________________________________

Secondary Phone Number_____________________________________________

Email______________________________________________________________

The best way and time to reach me

is________________________________________

Please return in the enclosed envelope, fax to (415) 458-3774, or email to
rramsey@dominincan.edu
APPENDIX C

Letter Sent to Participants Before Interview

Date

Participant name and Address

Dear (Name of Participant)

Thank you for agreeing to participate in the research study “The Professional Expertise of Community-Practicing Occupational Therapists”.

We have agreed to meet at (location) on (date, time) for the first interview. The interview will last approximately one hour. The interview will be audio taped, so that an accurate record will be preserved. After the first interview, we will arrange for a mutually convenient time for me to observe you working with one or more clients in the community. During transcription, any information, such as names or places that could identify you or your clients will be removed, so the information will remain confidential.

After the first observation and interview, I will conduct an initial review of the transcriptions. I will then contact you to arrange for a second follow up interview to clarify any questions I might have. Please take some time before our first interview to reflect on the following questions:

1. What is your experience like as a community practicing occupational therapist?
2. How does the experience compare to institution-based practice?
3. What is a typical day like for you? What parts of your job do you enjoy the most? The least?
4. How confident are you about having the skills and abilities you need to do your work?
5. How do you know when you are being successful in your work?
6. What are the most challenging and rewarding parts of your work?

I greatly appreciate your willingness to participate in this research study. Your contributions will help increase understanding of community-practicing occupational therapists, and may help promote more community practice in occupational therapy. Please feel free to contact me if you have any questions. I look forward to meeting with you.

Sincerely,

Ruth Ramsey, MS, OTR/L
(415) 933-9034/(415) 257-1393. rramsey@dominican.edu
I. Purpose and Background

Ms. Ruth Ramsey, a graduate student in the school of education at the University of San Francisco, is conducting a study on the experiences of occupational therapists in community practice. Specifically, she is interested in the professional development of community practicing occupational therapists. Occupational therapists are being urged to enter community practice, yet few have done so, and little is known about how they develop professional expertise.

I am being asked to participate because I am an occupational therapist in community practice.

II. Procedures

If I agree to be a participant in this study, the following will happen:

1. I will complete a short questionnaire giving basic information about myself, including age, gender, ethnicity, and job history.
2. I will participate in two interviews with Ms. Ramsey, during which I will be asked about my experiences as an occupational therapist in community practice.
3. I will be observed at a time and place of my choosing interacting with one or more of the clients served at my place of employment in a therapeutic process.
4. I may be contacted by telephone or email by the researcher as needed to clarify questions that come up during the transcription of the interviews.
5. I will complete the questionnaire, the interviews, and the observation at a location of my choosing in the community.

III. Risks and/or Discomforts

1. It is possible that some of the interview questions may make me uncomfortable, but I am free to decline to answer any questions I do not wish to answer or to stop participation at any time.
2. Participation in research may mean a loss of confidentiality. Study records will be kept as confidential as is possible. No individual identities will be
used in any reports or publications resulting from the study. Study information will be coded and kept in locked files at all times. Only study personnel will have access to the files.

3. Because the time required for my participation may be up to 2 hours, I may become tired or bored.

IV. Benefits

There will be no direct benefit to me from participating in this study. The anticipated benefit of this research is a better understanding of the professional expertise in community practicing occupational therapists, but this cannot be guaranteed. Sharing my experience may help me reflect meaningfully on my practice, which is considered a benefit for professionals, according to Schön (1983) and others, but this cannot be guaranteed.

V. Payment/Reimbursement

I understand that I will not be reimbursed in any way for my participation in this study.

VI. Questions

I have talked to Ms. Ramsey about this study, and have had my questions answered. If I have further questions about this study, I may call her at (415) 933-9034, at (415) 257-1393, or Dr. Robert Burns at (415) 422-5893.

If I have any questions or comments about participation in this study, I should first talk to the researcher. If for some reason I do not wish to do this, I may contact the IRBPHS, which is concerned with the protection of volunteers in research projects. I may reach the IRBPHS office by calling (415) 422-6091 and leaving a voicemail message, by emailing IRBPHS @ usfca.edu, or by writing to the IRBPHS, Department of Counseling Psychology, Education Building, University of San Francisco, 2130 Fulton ST. SF, CA, 94117-1080.

VII. Consent

I have been given a copy of the “Research Subject’s Bill of Rights”, and I have been given a copy of this consent form to keep.
PARTICIPATION IN RESEARCH IS VOLUNTARY. I am free to decline to be in this study, or to withdraw from it at any point. My decision as to whether or not to participate in this study will have no influence on my past or future status as a student or employee of the University of San Francisco.

My signature below indicates that I agree to participate in this study.

Subject Signature      Date of Signature

Signature of Person Obtaining Consent       Date of Signature
APPENDIX E

Informed Consent Form: Client

UNIVERSITY OF SAN FRANCISCO

CONSENT TO BE A RESEARCH SUBJECT

FOR USE WITH CLIENTS RECEIVING OCCUPATIONAL THERAPY SERVICES

I. Purpose and Background

Ms. Ruth Ramsey, a graduate student in the school of education at the University of San Francisco, is conducting a study on the experiences of occupational therapists in community practice. Specifically, she is interested in the professional development of community practicing occupational therapists. Occupational therapists are being urged to enter community practice, yet few have done so, and little is known about how they develop professional expertise.

I am being asked to participate because I am an individual with working with an occupational therapist in a community setting. I am legally able to give informed consent.

II. Procedures

If I agree to be a participant in this study, the following will happen:

1. I will be observed one time, for a period of 1-2 hours during a therapeutic interaction between an occupational therapist and myself. I will not be asked questions by the researcher. The therapeutic interaction may be in a group or individual setting.

III. Risks and/or Discomforts

1. It is possible that I will feel embarrassed or uncomfortable being observed by the researcher.
2. Participation in research may mean a loss of confidentiality. Study records will be kept as confidential as is possible. No individual identities will be used in any reports or publications resulting from the study. Study information will be coded and kept in locked files at all times. Only study personnel will have access to the files.
3. Because the time required for my participation may be up to 2 hours, I may become tired or bored.
IV. Benefits

There will be no direct benefit to me from participating in this study. The anticipated benefit of this research is a better understanding of the professional expertise of community practicing occupational therapists, but this cannot be guaranteed.

V. Payment/Reimbursement

I understand that I will not be reimbursed in any way for my participation in this study.

VI. Questions

I have talked to Ms. Ramsey about this study, and have had my questions answered. If I have further questions about this study, I may call her at (415) 933-9034, at (415) 257-1393, or Dr. Robert Burns at (415) 422-5893. If I have any questions or comments about participation in this study, I should first talk to the researcher. If for some reason I do not wish to do this, I may contact the IRBPHS, which is concerned with the protection of volunteers in research projects. I may reach the IRBPHS office by calling (415) 422-6091 and leaving a voicemail message, by emailing IRBPHS@usfca.edu, or by writing to the IRBPHS, Department of Counseling Psychology, Education Building, University of San Francisco, 2130 Fulton ST. SF, CA, 94117-1080.

VII. Consent

I have been given a copy of the “Research Subject’s Bill of Rights”, and I have been given a copy of this consent to keep.

PARTICIPATION IN RESEARCH IS VOLUNTARY. I am free to decline to be in this study, or to withdraw from it at any point. My decision as to whether or not to participate in this study will have no influence on my past or future status as a student or employee of the University of San Francisco.

My signature below indicates that I agree to participate in this study.

Subject Signature       Date of Signature

Signature of Person Obtaining Consent   Date of Signature
APPENDIX F

Research Subjects’ Bill of Rights

The rights below are the rights of every person who is asked to be in a research study. As a research subject, I have the following rights:

1. To be told what the study is trying to find out.
2. To be told what will happen to me and whether any of the procedures are different from what would be used in standard practice.
3. To be told about frequent and/or important risks or discomforts of the things that will happen to me for research purposes.
4. To be told if I can expect any benefit from participating, and if so, what the benefit might be.
5. To be told of the other choices I have and how they may be better or worse than being in the study.
6. To be allowed to ask any questions concerning the study both before agreeing to be involved and during the course of the study.
7. To be told what sort of medical or psychological treatment is available if any complications arise.
8. To refuse to participate at all, or to change my mind about participation after the study is started; if I were to make such a decision, it will not affect my right to receive care or privileges I would not get if I were not in the study.
9. To receive a copy of the signed and dated consent form.
10. To be free of pressure when considering whether I wish to agree to be in this study.

If I have other questions, I should ask the researcher. In addition, I may contact the Institutional Review Board for the Protection of Human Subjects (IRBPHS), which is concerned with protection of volunteers in research projects. I may reach the IRBPHS office by calling (415) 422-6091 and leaving a voicemail message, by emailing IRBPHS @ usfca.edu, or by writing to the IRBPHS, Department of Counseling Psychology, Education Building, University of San Francisco, 2130 Fulton ST. SF, CA, 94117-1080.
APPENDIX G

Letter Sent to Participants After Interview

Date

Participant Name and Address

Dear (name of participant),

I would like to thank you for your participation in the research study “The Professional Expertise of Community-Practicing Occupational Therapists”.

Your interview has been transcribed and any information such as names or places that could identify you has been removed during the transcription so that your information may remain as confidential as possible. The field notes have also had any identifying information removed from them to preserve your confidentiality. Your commitment to this research study has provided valuable insight into understanding the experiences of community-practicing occupational therapists. Please feel free to call me if you have any comments about the research process, or would like a copy of the findings.

Sincerely,

Ruth Ramsey, MS, OTR/L
(415) 933-9034 (or) rramsey@dominican.edu