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The Impact of Cooking Groups on One Individual's Transition to Independent Living

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THE IMPACT OF COOKING GROUPS ON ONE INDIVIDUAL'S TRANSITION TO INDEPENDENT LIVING

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DEPARTMENT OF OCCUPATIONAL SCIENCE AND OCCUPATIONAL THERAPY

This project, written by Alison Garcia under direction of Dr. Christine Privott, Faculty Mentor, and approved by members of the project committee, has been presented and accepted in partial fulfillment of requirements for the degree of

DOCTOR OF OCCUPATIONAL THERAPY

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Certification

We hereby certify that this Capstone project, submitted by Alison Garcia conforms to acceptable standards and is fully adequate in scope and quality to fulfill the project requirement for the Doctor of Occupational Therapy degree.

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Executive Summary

Background: Independent community living is a common goal for many adults hospitalized in an inpatient psychiatric hospital. Chronic, long-term hospitalizations often result in institutionalization, or a loss of functional and psychosocial skills required for independent living. The goal of occupational therapy in this setting is to develop independent living skills and restore normative life roles vital for leading a fulfilling life in the least restrictive environment. In one psychiatric hospital, cooking groups are an essential intervention and environment in which to develop these skills and roles.

Purpose: The primary purpose of this study is to describe OT cooking group programing in one inpatient psychiatric setting while understanding one client's experience with cooking groups and illustrate how her participation in these groups led to a successful transition to independent living. The secondary research objective was to understand the challenges facing individuals transitioning from institutionalization to independent living and the role of OT in providing support.

Theoretical Framework: This study was guided by the transformative worldview which focuses on empowering the individual and combatting oppression in marginalized populations. This study sought to challenge the stigma surrounding long-term psychiatric clients by highlighting the capability and strengths of one individual's recovery.

Methods: This study reflects a qualitative case study approach, using retrospective data analysis to describe the case of one client in OT cooking groups and the impact on her transition to independent living.

Results: A total of 220 documents were analyzed from the individual's records and were categorized into three data sources: provider notes, OT progress notes, and the patient's daily goal sheets. The raw data was hand coded and thematic analysis was used to compare and contrast codes across three data sources. Patterns of codes that were consistent across the data sources were refined into five themes.

Conclusions: Themes that emerged consistently across the data illustrate that OT cooking groups were an important aspect of the client's recovery. Patterns between cooking group and improved mood and hygiene were a significant finding, as well as helping the individual find a sense of belonging and family. Other themes illustrated specific challenges and barriers experienced by the consumer, and the role of OT cooking groups in promoting skills, supports and relational roles to overcome challenges.

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My patients – thank you for trusting me with your stories. I promise to use them to help the world understand your capabilities as well as your struggles, and to continue working to make the world a more welcoming place for you to thrive.

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CERTIFICATION OF AUTHORSHIP

Submitted to (Faculty Mentor's Name): Dr. Christine Privott
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Certification of Authorship: I hereby certify that I am the author of this document and that any assistance I received in its preparation is fully acknowledged and disclosed in the document. I have also cited all sources from which I obtained data, ideas, or words that are copied directly or paraphrased in the document. Sources are properly credited according to accepted standards for professional publications. I also certify that this paper was prepared by me for this purpose.

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Date of Submission: November 17, 2020

Table of Contents

List of Tables

Section One – Nature of Project and Problem Identification

Introduction

According to the World Health Organization (2018), mental illness is one of the leading and fastest-growing forms of illness and disability worldwide. Serious mental illness is reported to contain the largest burden of illness within the United States (NIHM, 2018). For patients with serious mental illness, the goal of occupational therapy is to develop the skills and supports to achieve community integration, meet normative life roles and lead a productive, fulfilling life within the least restrictive environment (AOTA, 2020).

While the historical roots of occupational therapy (OT) trace back to mental health practice, AOTA (2014) identifies this practice area as a high-need, priority research area. The shift towards mental health treatment based on a person-centered recovery model (SAMHSA, 2018) combined with AOTA's efforts to focus on mental health has created an opportunity for OT to resume a more significant role in psychosocial rehabilitation. In addition, it also highlights the need for continued research that supports recovery-based outcomes and the effectiveness of specific interventions in supporting mental health recovery (D'Amico et al., 2018).

Living independently in the community is typically the common goal for most adults hospitalized in an inpatient psychiatric hospital (Killaspy, 2016); however, it is not always possible to discharge patients independently and safely into the community due to varying levels of assistance required to complete more complex tasks such as instrumental activities of daily living (IADLs). The American Occupational Therapy Association (AOTA, 2014) defines IADLs as "activities that are oriented toward interacting with the environment, and are often complex." A review of OT literature shows the need for more research to support specific intervention

strategies for helping patients with acute mental illness achieve IADL skills required for independent living.

Abbreviated Literature Review

Occupational therapy scholarly literature supports a range of therapeutic benefits associated with cooking groups, specifically with individuals facing mental health challenges. A systematic review by Farmer et al. (2018) explored the influence of cooking interventions on psychosocial outcomes and found that the benefits of cooking include positive influence on socialization, self-esteem, quality of life and affect. Likewise, significant qualitative studies describe cooking as a cultural experience (Pierce et al., 2018), explore and compare the contexts in which cooking takes place (Duncombe, 2004), and describe client attitudes towards cooking as a meaningful and productive experience (Haley & McKay, 2004).

Few studies look specifically at meal preparation as an intervention or performance measure (Clark et al., 2015), and few studies specifically measure instrumental activities of daily living (IADLs) in individuals with mental illness (Farmer et al., 2018). Cooking skills provide an opportunity for OTs to advocate for less restrictive environments for their clients, since a client who is skilled in cooking tasks can often generalize those skills to other areas such as safety awareness, following directions, problem-solving, sequencing and planning (Cook, 2008).

Problem Statement

This project addresses a two-fold problem. The primary problem is the lack of understanding of the functional benefits of cooking groups in the psychiatric setting beyond its benefits as a valued, enjoyable occupation (Pierce et al., 2018, Haley & McKay, 2004). The second problem is the lack of specific evidence for using cooking groups as an intervention

strategy for assisting clients in the psychiatric setting to reach the goal of transition from institutionalization to a least restrictive setting (Clark et al., 2015, Farmer et al., 2018).

Purpose and Objectives

The purpose of this study is to describe a within-site case of cooking group programming at one inpatient psychiatric setting, using one client's experience to illustrate the impact of the OT cooking groups on her transition to independent living. The primary research objective of this study is to describe occupational therapy cooking group programming and more specifically, illustrate how one client's participation in cooking groups resulted in transition to independent community living. The second research objective is to understand the unique challenges facing individuals transitioning from institutionalization to independent living.

Theoretical framework

Individuals with mental illness are considered a marginalized population due to deeply ingrained social and cultural stigma surrounding mental illness. The effects of stigma can be devastating for individuals and their families and can include oppression, discrimination and cause barriers to health care, employment and housing (Knaak et al., 2019, Corrigan, 2005). These problems are not only caused by social stigma, which involves a lack of understanding and inclusion by others, but often include self-perceived stigma, in which an individual experiences an internalized sense of shame for having a mental illness resulting in decreased levels of self-confidence and motivation (Corrigan et al., 2009).

This project aligns with the transformative worldview (Mertens, 2009), in that it focuses on empowerment and combatting oppression in marginalized populations (Creswell, 2014). Transformative research places central importance on the study of the lives and experiences of

diverse groups that have traditionally been marginalized and the strategies they use to overcome challenges (Mertens, 2009). From the transformative worldview, the goal of this research is not only to understand the experience, challenges and barriers of clients working towards independence, but to advocate for them to thrive in the least restrictive environments and to challenge the stigma that might obstruct their success.

OT cooking groups are an integral part of the Recovery Mall, which is a person-centered, recovery-based, active treatment program within a psychiatric facility. This program is built on the Substance Abuse and Mental Health Service Administration's (SAMHSA) Recovery Model which defines mental health recovery as "a journey of healing and transformation that enables a person to live a meaningful life in a community of his or her choice, while striving to achieve maximum human potential (SAMHSA, 2006)." This definition is reflected throughout many dimensions of the program which supports the individual in achieving their goals in a meaningful, personalized way. The central theme of this study is to illustrate the healing journey and transformation of one individual as participation in cooking groups provided advocacy, skills and self-confidence to transition to living independently.

Significance of the project

The description of a within-site case of cooking group programming at one psychiatric setting and the use of one client's story to illustrate a successful transition into independent living may allow OTs to gain a deeper understanding of the experience of transitioning from institutionalization to independent living. Furthermore, OTs can use the knowledge gained in this study to examine the effectiveness of transitional program planning such as cooking group interventions in psychiatric institutions.

Section Two – Literature Review

The aim of the literature review is to examine current literature exploring cooking groups as a method for assisting individuals with mental illness in their transition to independent community living. The importance of group process and meaningful activity in general are explored as a therapeutic process in mental health recovery as well as the psychosocial benefits of cooking.

The Meaning of Cooking

The operational definition of cooking simply refers to the act or process of preparing food (Miriam-Webster, n.d.), as compared to the "phenomenon" of cooking which is abstract and multifaceted. The occupation of cooking is extremely complex and often deeply tied to emotions, memories, habits, roles, beliefs and cultures that are highly personal, individualized and may vary significantly depending on a person's unique history and context (Wolfson et al., 2016).

Several studies suggest consistent themes about cooking across cultures including cooking as a form of cultural identity and expression and its role in nutrition, family, tradition and storytelling. Pierce et al (2018) found in a cross-cultural study of older women preparing celebratory foods, that cooking shares similar meaning across cultures and is associated with expressing regional identity, celebrating family and maintaining tradition. Similarly, Bietti et al. (2019) found that cooking was taught and learned across cultures through storytelling as a method for different generations to exchange information through traditional family recipes. The authors discovered that the collaborative and culturally meaningful aspects of cooking made it a useful vehicle for transmitting cultural information and storytelling. Wolfson et al. (2016) studied perceptions of what it means to cook in the United States culture and suggested that

perceptions of the meaning of cooking were complex but included degree of time, effort and love associated with food preparation.

The concept of cooking as a bonding activity between family and friends was also illustrated in several studies. Gustafsson & Sidenvall (2002) and Sidenvall et al. (2000) found that when meals are consumed with family or friends, the preparation of meals is associated with socialization and pleasure. A similar study found that preparation of shared meals was positively associated with life satisfaction (Haak et al., 2006). Likewise, a study highlighting a cooking program in Appalachia showed that the meaning of cooking was strongly tied to family attachments (Hardin-Fanning & Ricks, 2016). Participants described bonding with family members during the act of cooking, planning meals that family members would enjoy and reminiscing over traditional family meals. Not surprisingly, family and a strong sense of community were described as deeply held values of Appalachians which were reflected in their experiences of cooking.

Eckel et al. (2012) studied community dwelling women and perceptions of cooking and found that cooking was perceived to be one of the most important skills necessary for aging in place and contributed to the preservation of sense of self, identity and quality of life. Similarly, Wolfson et al. (2016) found that cooking was an important daily routine tied to self-identity and specific family roles. Additionally, resources, organization and time management were commonly described as necessary for enabling daily cooking routines and roles.

Psychosocial Benefits of Cooking

A systematic review of peer-reviewed literature by Farmer et al. (2018) suggests that the benefits of cooking extend beyond nutrition and include positive influences on socialization,

self-esteem, quality of life and affect. Although this evidence was preliminary, it strongly suggests that cooking interventions may positively affect psychosocial outcomes in a range of populations.

Fitzsimmons and Buettner (2013) found that after completing a two-week cooking program in a residential facility, participants demonstrated a significant improvement in agitation and apathy. Results suggested that the cooking groups motivated the residents to attend, socialize, perform cognitive activities in a small group and enjoy a shared experience which ultimately improved overall affect. While this was the only study that specifically connected cooking with "affect," an earlier study by Hill et al. (2007) connected cooking groups with mood, which is closely related to the concept of affect since an individual's affect is often used to assess or predict their mood (Serby, 2003). In the Hill et al. (2007) study, burn patients' perspectives of cooking illustrated how cooking groups therapeutically impacted participants' moods by decreasing anxiety, and increasing socialization.

In a qualitative study of the occupation of baking, Haley and McKay (2004) explored the perspectives of individuals with mental illness and their experiences with baking and found that most participants described an increase in both confidence and concentration after learning baking skills. A later study by Conner et al. (2018) confirmed that people who frequently engage in creative projects like baking or cooking report feeling more relaxed and happier in their everyday lives, suggesting an association between creativity and emotional functioning.

Several different cooking programs were highlighted in the literature with the goals of promoting targeted functional and nutritional skills, but programs also reported unexpected secondary psychosocial benefits such as confidence and self-efficacy (Schmelzer et al., 2018,

Clark et al., 2019). Schmelzer et al. (2018) investigated a program that aimed to promote health through occupations that maximize food resources. They found that participants made improvements in building confidence and establishing habits in addition to improving occupational performance and food security. Similarly, a six-week cooking program for individuals with severe mental illness showed that participants demonstrated improved eating behaviors and cooking skills but also reported increased levels of self-efficacy regarding cooking and eating healthier (Clark et al., 2015).

Nickrand & Brock (2017) explored grief counseling that used cognitive behavioral therapy centered on meal planning, grocery shopping, meal preparation and eating activities after the loss of participants' loved one. Participants reported these were effective strategies for overcoming manifestations of grief including irrational beliefs, feelings of depression or anger and avoidance or numbing behaviors. In a similar study, von Essen and Mårtensson (2017) suggest that in addition to coping with negative emotions, cooking can also be used to promote positive emotions and build emotional resilience. The authors used life narratives and attachment theory to understand how young adults use emotion-related food memories to build resilience and problem-solving.

Cooking as an Intervention

According to a systematic review of OT interventions for adults with mental illness (Gibson et al., 2011), meal preparation (including planning, grocery shopping, cooking and clean up) is an IADL that few research studies have investigated. However, this is an essential IADL for successful independent community living. Gibson et al. (2011) also found that while some studies examined IADLs such as health management and community mobility, there was little

research which used IADL performance as an outcome measure in individuals with mental illness.

Several studies compared and contrasted different approaches for developing life skills including cooking (Tunkgpunkom & Nicol, 2008, Grimm et al., 2009, Helfrich et al., 2011). Tungpunkom & Nicol (2008) compared behavioral and cognitive approaches for skill development and found that regardless of whether behavioral or cognitive approaches were used, skills training was consistently effective across studies in improving life skills and reducing psychiatric symptoms. The reviewed studies used outcome measures such as skill acquisition, reported symptom reduction and hospitalization rates which highlights the lack of validated measurement tools and functional assessments in the area of cooking (Tungpunkom & Nicol, 2008). A similar study by Grimm et al. (2009) compared two treatment approaches to improve cooking skills in adults with schizophrenia: acquisition approach and psychoeducational approach. Occupational performance in the area of cooking was assessed pre- and post-intervention using the Performance Assessment of Self Care Skills (PASS) and showed that OT intervention improved cooking skills in adults with schizophrenia. Both acquisition and psychoeducational approaches were found to be helpful in preparing clients for community discharge (Grimm et al. 2009).

A later study by Helfrich et al. (2011) examined the effectiveness of life skills interventions for people with mental illness who were also homeless. Participants completed life skills training which targeted cooking among other IADLs and were assessed using the Allen Cognitive Level Screen (ACLS) and the Practical Skills Test (PST) before, during, and after the skills training. The results indicated that regardless of initial ACLS level, participants retained

and improved life skills knowledge over time, suggesting that people with a wide range of cognitive abilities can demonstrate improvement in IADLs such as cooking after OT intervention.

Cooking interventions are not only important for the acquisition of functional skills required for independent living, but also have a positive impact on nutrition, which is a high area of concern for individuals with mental illness (Bottomley & McKeown, 2008). According to Cook et al. (2016), individuals with severe mental illness commonly have comorbid medical conditions including metabolic disorders, obesity, substance abuse and addition. In addition, many individuals with mental illness have physical and socioeconomic barriers to accessing healthcare services and education, making nutrition an area of need (Koyonangi, 2004). Preliminary studies suggest that nutrition-focused cooking programs for individuals with mental illness may be effective in increasing self-efficacy related to cooking, improving nutritional knowledge and healthier eating behaviors (Clark et al., 2015). A study by Brown et al. (2002) supports the use of cooking programs that incorporate grocery shopping skills to help individuals with mental illness improve the executive functions skills needed to evaluate foods for nutritional value.

The significance of cooking interventions on long-term patients is acknowledged in studies by Forchuk et al. (1998) and Bellus et al. (2000). Forchuk et al. (1998) examined patient and staff perspectives of the discharge process and found that cooking groups were reported as effective in promoting successful community reintegration. Specific elements of cooking groups that supported successful discharge included working with familiar staff members and instilling hope for life outside the hospital through learning bus routes, grocery shopping and establishing

connections with community supports. Bellus et al. (2000) also explored the process of community reintegration for long-term patients and found cooking groups to be a helpful intervention in the case of individuals who experienced symptoms of institutionalization such as apathy, lack of initiative and unwillingness to leave the hospital setting. In addition to preparing the individual mentally, emotionally, and socially for successful return to the community, Bellus et al. (2000) suggested that it is equally important for therapists to address independent living skills required for transition.

Group Work in Mental Health

A wide range of benefits are attributed to participation in activity-based groups which involve group members learning by actively doing rather than being passive participants or using verbal skills alone (Barlow et al., 2000). Activity groups are used extensively in inpatient mental health programming as a way to both develop functional skills and promote social interaction and social learning (Finlay, 2004). One of OT's central philosophies is that humans define their lives, cultures, values and worth through activities. This supports OTs use of activity groups as a powerful therapeutic tool (Cole, 2005). The goal of OT cooking groups are to work collaboratively not only between patients, but between therapists, peers and community members (Alguire et al., 2007). In the inpatient mental health setting, cooking in groups is more likely to result in occupational engagement by focusing on building rapport and enabling co-occupation between patients and those that support them (Bullock, 2011).

One advantage of facilitating cooking interventions in a group setting is that cooking is commonly associated with culture and family. According to Creswell (2007), a culture-sharing group shares learned and acquired behaviors including common interests, values or the following

of a particular code. Long-term mental health patients often feel estranged or ostracized from their families and society in general and being part of a cooking group fosters a sense of belonging to a group or culture that enhances participation and psychosocial benefits (Reiks, 2014). In a recent mixed-methods study by De Vos et al. (2019), individuals in an inpatient mental health setting participated in an OT cooking group and provided valuable insights to their experiences. Overall, the participants reported they enjoyed participating in the group, felt the experience was important to their recovery and planned to continue using the skills after discharge. Interviews with the participants highlighted several themes including the importance of engaging with others, the importance of doing, connections with food and being involved in a group process (De Vos, et al., 2019).

Summary

The literature suggests that multiple potential benefits are associated with cooking groups for individuals with mental health diagnoses. Scant evidence exists addressing the specific relationship between cooking groups and successful community transitions for long-term patients. This scarcity of evidence may be partly due to the wide variations between programs, individuals and diagnoses which can make it difficult to generalize methods and results. Long-term psychiatric patients face challenges as they transition to the community, and the literature suggests there are specific ways that OT cooking groups may help overcome these challenges.

Section Three – Methods

Project Design

This study is a qualitative, within-site case study design using retrospective data analysis to describe the case of one purposefully selected client in an OT cooking group program and the impact on her transition to independent living. The rational for selecting a qualitative design is to provide rich, descriptive data describing current programming, as well as an in-depth understanding of one individuals' journey from chronic institutionalization to independent living. This aligns with the transformative and recovery model worldviews which are highly client-focused and seek to give power and voice to the individual (Creswell, 2014, SAMHSA, 2006).

Setting

The OT cooking group program in an inpatient psychiatric hospital is the broader setting being examined and described; however, since the study was retrospective in nature and no intervention was actively occurring at the time of study, the specific setting was technically the collection of archival documents that were reviewed and analyzed. A fuller description of these documents is included in the data collection and data analysis sections.

For this study, the OT cooking groups are defined and programmed as three parts which clients enroll in simultaneously: Meal Planning, Grocery Shopping and Meal Preparation. For the sake of abbreviation, these sub-groups are all referred to as Cooking Groups. In the meal planning section clients collaborate to select a menu and compose a grocery list based on the items needed. Clients are educated on cost and nutrition but generally have autonomy in the meal selection. Clients then go into the community to complete grocery shopping with supervision by OTs who encourage consideration of budgeting, nutrition information, navigation and

appropriate interactions with community members. Lastly, clients work together to cook and eat the meal they planned and shopped for.

Inclusion/exclusion criteria

Primary inclusion criteria was determined to be archival document review of one purposefully identified client who:

- was a former participant of the cooking group programming for five months
- has a severe, persistent mental illness diagnoses
- has a history of chronical institutionalization for greater than thirty years
- has successfully transitioned to independent living
- has been living in the community for approximately one year without readmission
- is a middle-aged female

Exclusion criteria for this study are any institutional or archival document review of any individual other than the purposefully selected client.

Project methods

Purposeful selection of the records of one psychiatric client, who was a long-term participant in one institution's OT cooking groups, was employed. The client's five months length of time and active level of participation in the cooking group treatment as documented in her medical records provided rich data for this study. A retrospective record review provided valuable insights about the client and her functioning. After approximately thirty years of chronic institutionalization, the client successfully transitioned to independent living in the community.

Data collection

The electronic medical record and hard paper medical chart of the client are the archival materials accessed for this study. Sources of data included all written notes in the client's medical chart. Parameters were placed in order to reduce the data by relevance and time frame because of the magnitude of data within the chart. This data-reduction strategy is described as "winnowing" by Creswell (2013), and is used in cases where the data is so dense and rich that not all of the information can be used in a qualitative study. This results in a process where relevant data is selected for focus and other parts are disregarded (Creswell, 2013). Documents from the one year in which the client had participated in cooking group were purposefully selected. Some documents outside this timeframe were included in order to compare and contrast patterns in behavior before and after participation in cooking group. Documents from prior admissions and years where the client was not involved with OT groups were excluded as part of the data reduction.

In order to provide thick and rich description, an effort was made to include several different types of documents from various disciplines and perspectives. After comprehensive review of the documents within the selected parameters, the bulk of relevant information was found to be written from the perspective of the patient's providers – psychiatrists and advanced practice registered nurses (APRN), OT staff and from the client's perspective using her own words. Table 1 is an illustration of the documents analyzed.

Table 1
Documents included in review

Type of document	Perspective provided	Contributor
Provider Progress Notes	• Provider's perspective • Often describes the consensus of the multi-disciplinary recovery team • Includes patient perspective with direct quotes from daily rounding and interviews with patient	• Psychiatrist • APRN • Direct patient quotes
OT Group Notes, Progress Notes and Evaluation Reports	• OT perspective • Patient perspective through interviews & quotes	• 2 staff OTs • 1 COTA • 2 OT students (reviewed and co-signed by OTs)
Daily Goal Setting Sheets	• Patient perspective	• Solely the patient's responses, recorded by nursing staff

The client's history, background and demographics were collected from the providers' notes, the admission history, and the occupational profile documentation. The goal of including this unidentifiable client demographic information was to disclose enough background to provide context and meaning to the case without disclosing data that could potentially identify the client.

All data was collected and organized in a de-identified fashion prior to analysis and only the PI knows the identity of the individual in order to safeguard against a confidentiality breech. This was accomplished by transferring raw data from the hard chart into a Microsoft Word document without any identifiers included. Direct quotes and relevant chunks of interviews and data were typed by hand into the document in chronological order and by document type in the PI's private locked office on-site at the hospital. The hard chart was then returned to the medical records department and the de-identified chunks of data were analyzed. While this was a time

consuming process, it was an effective data-reduction strategy which condensed thousands of pages of medical charts into a twelve-page document of de-identified raw data that was strongly relevant to the case, and organized for coding.

Data analysis

Data analysis was completed over a three-week period and began with an a-priori approach using the three determined data sources (provider, OT and client notes) to search for data relevant to cooking groups. A-priori is a process of coding qualitative data in which the researcher develops codes before data analysis based on existing knowledge (Miles, 2014). This was followed by an emergent coding approach to search for patterns arising from the three data sources already established. Since transformative research focuses on empowering the participants, it was important that the research plan was not rigidly prescribed, but allowed to shift and develop around the best way to understand and highlight the client's experience (Creswell, 2013). Using an emergent approach to coding the data within the predetermined sources was important in order to generate the meaning of experiences as well as compare and contrast similarities and differences between different data sources (Taylor, 2017).

During the data collection phase, the first step of data analysis was simultaneously occurring as the documents were being visually scanned, organized and loosely analyzed for relevance and significance to the topic. This is described by Corbin & Struass (2008, p. 176) as a "first pass document review" where meaningful and relevant texts are identified and separated from those that are not pertinent. The de-identification stage of the data was also a preliminary type of data analysis. As the raw data was being typed into a document allowing a first look or read-through of the selected data, general impressions were being formed about the meaning of the data based on tones and patterns that were immediately evident to the researcher. These

initial impressions were noted in an informal journal that documented an audit trail of the researchers thought process and decisions during data collection.

The preliminary impression that struck the researcher during transcription of the data was that each type of documentation was written in a different tone or perspective depending on the contributor. The provider notes were focused on the client's symptoms, behaviors and challenges. The OT notes documented functional challenges with a significant focus on the client's behavioral strengths and skills. The client's self-report appeared to focus on her feelings and emotions. Table 2 illustrates this first level of analysis.

Table 2
Initial impressions of data

Contributor	**Focus of documentation**	**Quote**
Provider	• Symptom burden	• "The patient displays attention-seeking behaviors, becomes verbally aggressive when things don't go her way." • "The patient has difficulty accepting any responsibility in her behaviors or situations."
	• Behavioral Challenges	• "The patient's behavioral and legal history is making placement difficult"
Occupational therapist	• Functional challenge	• "The patient required moderate verbal cues for visual scanning to locate grocery items."
	• Behavioral strengths	• "Patient was pleasant and engaged. Was supportive to peers and volunteered to do cleanup."
	• Functional Skills	• "Pt. independently cooked an entrée using her own recipe from memory and demonstrated good safety awareness and hygiene."
Patient	• Feelings and emotions	• "No one cares about me" • "I'm depressed that no one wants me." • "I'm frustrated they haven't found a place for me yet." • "I'm excited to go and finally be free."

The next step was emergent coding of each data set separately (provider's notes, OT notes, and client's self-report goal sheets). A comparative method was used to check/re-check and compare codes across the data sets. This allowed the PI to pinpoint ideas and concepts that clustered together and identify similarities, differences and general patterns (Bowen, 2009). Themes were then discovered from codes that were consistent across all three data sets. Table three provides specific examples of codes that emerged across data sets.

Table 3
Initial codes

	Provider Notes	**OT Notes**	**Patient Goal Sheets**
Similar codes	Cooking group Grocery shopping Motivation Confidence Hygiene Family Mood	Cooking group Grocery shopping Motivation Confidence Hygiene Family Mood	Cooking group Grocery shopping Family Mood
Unique codes	Legal history External locus of control Maladaptive coping Attention seeking Acting out behaviors Advocating for herself Suicidal ideation/gestures Behavior in community "Nobody cares"	Engaged Collaborated/cooperated Independent Pleasant/helpful Safety Visual scanning Following recipes Budgeting Nutrition	"Just make it through the day" "Just get off the unit" "Have a good day/do good" "Stayed busy"

The PI expected to find multiple codes related to cooking groups, grocery shopping and preparing food based on the data analysis approach. The PI did not expect the volume and frequency in which these codes appeared throughout all of the data sets.

After the initial codes were color-coded by hand, the PI read through the data sets multiple times resulting in further condensing of similar codes to generate five themes which illustrated consistent patterns across the data. An extensive document key was created as part of

the audit trail with multiple tables listing all codes categorized by data set and connecting them to the major themes. The final themes became:

- Patterns between cooking and mood
- Patterns between cooking and hygiene
- The process of cooking as a goal, intervention, and outcome measure
- Finding family/belonging through cooking
- Challenges to independent living after institutionalization.

Trustworthiness

As the sole interpreter of data in this document analysis, the researcher attempted to make the processes as rigorous and transparent as possible. According to Elo et al. (2014), the trustworthiness of content analysis depends on the availability of rich, appropriate and well-saturated data. The trustworthiness and rigor of data collection was verified by providing precise details regarding the types and quantity of documents selected as well as description of the content, focus and contributors or writers of each document type.

The sheer volume of data in the reviewed chart illustrates rigor and saturation. A form of triangulation was also used by including multiple data sources and perspectives from within the record reviewed. These are referred to as the three data sets, (provider notes, OT notes, and client daily goal sheets) and provide three different perspectives or focus areas. This gives trustworthiness and significance to the themes because they can be verified across all three data sources, confirming that they are important to the case. According to Creswell (2014), the process of establishing themes by converging several sources of data or perspectives adds to the

validity of the study. Triangulation of data sources also counters threats to trustworthiness such as bias and reactivity (Bowen, 2009).

Member checking was not feasible because the document review was retrospective in nature; however, a research mentor was involved in reviewing the study at different points in the process, and asked questions and provided guidance in order to help the study resonate with other individuals than the researcher. Creswell (2014) describes this process of involving interpretation beyond the researcher as enhancing the overall validity.

Ethical Considerations

Individuals with mental illness are considered a vulnerable population, thus, ethics are carefully considered in the areas of informed consent, protecting privacy and stigma (DuBois, 2008). An application was submitted to the Institutional Review Board (IRB) and the study was determined to be exempt from review. The IRB determined neither informed consent nor review was required due to the retrospective, single case, document review design and the researcher's plan to de-identify any personal identifiers or protected health information (PHI). Per the IRB's recommendation, HIPPA guidelines were followed when accessing, handling and de-identifying the raw data.

This issue of stigma remained an ethical consideration throughout this study. Social stigma associated with mental illness combined with generalizations and assumptions can lead people to exaggerate the deficits and vulnerabilities of individuals with mental illness and to overlook or discount their strengths (Corrigan, 2005). Transformative research agenda seeks to confront social oppression and injustice at whatever level it occurs (Mertens, 2009). Using a transformative lens, it was the aim of the researcher to present the client's case with dignity and

appreciation for her full personhood, life experiences, and capabilities. The researcher considered it equally important to safeguard the client's dignity as well as her privacy.

The researcher completed training through Collaborative Institutional Training Initiative (CITI) in order to satisfy EKU's requirements for conducting research. As a mental health practitioner, the researcher also completes yearly training in HIPPA guidelines and is knowledgeable in determining what information is considered PHI, how and when it can be accessed and disclosed, and measures for protecting it. No conflict of interest is declared.

Section 4: Results and Discussion

Introduction

The purpose of this qualitative, within-site case study was to use retrospective record review to illustrate one client's experience with an OT cooking group program and to understand how her participation in this intervention supported her transition to independent living. The secondary purpose was to understand the challenges or barriers the client overcame to achieve independence after being institutionalized and the role of OT in that process.

Occupational profile of the client

The purposefully selected client in this study was a middle-aged female who was a long-term consumer of mental health services. Her primary diagnosis was major depressive disorder with psychotic features and included a secondary diagnosis of borderline personality disorder with antisocial traits. The client's contextual and environmental background included being raised in poverty in rural Appalachia. She experienced many adverse childhood events and trauma throughout her young life resulting in her introduction to the mental health system as a young teen for difficulty dealing with anger and aggression.

Other significant life events that occurred within a short period of time included marriage as a young teen to an abusive spouse, divorce, re-marriage, child-bearing, death of family members, and entering the justice system where she served many years. The client revealed few details about her years spent in incarceration but she reflects in the documentation that her spouse died during that time and she was not able to sufficiently grieve or process his death. This appeared to trigger a pattern of depression, self-harm and suicidal gestures that continued for years afterwards.

After the client's release, her significant legal history followed her and she often found herself ostracized and stigmatized resulting in complications in each living situation she was placed. She was often described as "institutionalized" due to the long incarceration and did not have the skills needed to live independently. Several short stays at personal care homes were not a good fit for the client and ended in psychiatric hospitalizations. Throughout the data multiple providers, as well as the client herself, describe a gradual internalization of negative beliefs resulting in chronic feelings of worthlessness and hopelessness, which is known as self-stigma.

As she began to improve and participate in recovery mall groups, the client discovered a love for cooking which became a valued occupation. OT notes describe low confidence and motivation initially and noted that she required education to learn the use of modern appliances. However, she quickly became independent and enjoyed cooking traditional Appalachian foods from memory as well as learning to read and follow new recipes. She frequently described cooking group as her coping skill and referred to cooking group as her family. Her pride in her accomplishments was illustrated in the provider notes that frequently began with a quote from the client describing what she had cooked the previous day. The following quote from one provider's note describes her overall journey to independence:

> "When the patient first came to the hospital, she was quite despondent. She slowly started to improve and stated that she wanted to get better and knew she had things to live for. This varied from time to time as she would often get frustrated with ongoing hospitalizations or when she felt she was being treated unfairly. Most setbacks in mood were related to personality pathology, so medication changes were made. At the time of her discharge she stated she was very hopeful and excited to be finally living on her own. She was excited to have her own place and 'finally be free.' She worked with occupational therapy to learn to navigate the bus system and with grocery shopping and cooking skills. She seemed to really enjoy cooking and having something purposeful for her to do was vital in helping her maintain

> appropriate behaviors. Neatly groomed and appropriately dressed with fair hygiene. Her affect is bright. She is discharged to her own apartment."
> – Provider's discharge note

Results

A total of 220 documents were analyzed from one admission and made up the three data sets. Seventy-five of those documents were providers' notes, seventy documents were OT notes and seventy documents were the client's self-reported daily goal sheets. From the total 220 documents, 151 of them mentioned cooking group or similar phrases (the terms "grocery shopping" and "meal-planning" are included because they are part of the cooking group program). Table four illustrates how the data was saturated with the concept of cooking groups.

Table 4
Cooking group frequency in the data

Provider notes	OT notes	Patient daily goal sheets
32/75 documents mention cooking groups	70/70 documents mention cooking groups	49/75 documents mention cooking groups

Cooking groups are clearly an important concept throughout the client's recovery and a consistent pattern across the data sets; however, each data source referenced cooking groups in different contexts and associated cooking group with different meanings and patterns which made up codes (see table 3). These codes or different concepts and patterns associated with cooking group are categorized and described in five themes (See table 5).

Themes

According to Braun & Clarke (2006), themes are a way of telling an overall story about the data. In order to maintain rigor and transparency, it is important to clearly show how each theme was derived from the data. This is accomplished by returning to the raw data and comparing it to the developed themes to make sure that all conclusions are firmly grounded in the data (Braun & Clarke, 2006). Table five illustrates how the initial codes were refined and condensed to form the final themes, reinforced by sample quotes from the raw data.

Table 5
Themes, corresponding codes and representative quotes

Theme	**Codes**	**Quote**
Patterns between cooking and mood	Cooking group Mood/affect Engaged Sense of purpose Proud of me	"Pt.'s mood was improved after she returned from cooking group. She was excited to tell me about the meal she cooked."
Patterns between cooking and hygiene	Cooking group Hygiene/Dress/grooming	"Pt. is up and about the unit this morning. Dressed appropriately in street clothes with good hygiene and eye contact. She is planning to go grocery shopping with the OT for cooking group today."
Cooking as a goal, intervention and outcome measure	Motivation Confidence Independent living skills Safety Visual Scanning Behaviors in community Sense of purpose	"My goal is to have a good day in meal prep today." "Pt. continues to work with OT on shopping and cooking in hopes that she can go to an independent living situation." "The team discussed allowing her to go to a conference today. Since she has been doing well and having appropriate behaviors with

		cooking groups and shopping in the community, we are confident she will be able to do so today."
Finding family/belonging through cooking	Supportive to peers Helpful Collaborated/cooperated Caregiver role Family Sense of purpose	"We're like a little family. Me and the OTs in cooking group. We all have our jobs to do, we all pitch in and help and then we sit down and eat together just like a family."
Challenges to independent living after institutionalization	Legal history Maladaptive coping External locus of control Independent living skills Self-Advocacy	"Her legal and behavioral history is making placement challenging." "Essentially institutionalized given her long incarceration, unable to maintain herself in the community and requires assistance with almost all independent living skills."

Patterns between cooking and mood

Each data set referred to cooking groups with different contexts and meanings; however all three data sets consistently referenced cooking groups in the context of the client's mood. This was the most significant and consistent pattern that emerged across all data sets. In the provider's notes, the writers were frequently assessing and describing the client's mood from day to day. OT notes also assessed the client's mood at every group, as is standard practice especially for patients with mood disorders. The client rated her mood daily on a scale from 1-10 on a daily goal sheet. The goal sheet prompts her to rate her mood, set a goal for the day, and then later assess whether or not she met her daily goal and what was or was not helpful.

The provider's notes use descriptive language to assess the client's mood. Each time the client is noted to participate in cooking groups or talks to the provider about cooking groups, her mood is described as being positive. Occasionally, the provider noted that she was tearful in the

morning, but had improved mood after returning from cooking. Conversely, the client expressed frustration at times due to not being able to attend cooking groups. Table six illustrates some of the descriptive terms used to reflect the patterns of her mood in relation to cooking group attendance.

Table 6
Provider description of mood patterns

Client attends cooking group	**Client stays on the unit**
Provider's descriptors of mood: "Not feeling as down. Seems hopeful." "Appears to be feeling hopeful." "Excited about going shopping with OT" "Good mood" "Pleasant" "Euthymic mood" "Smiling, calm, cooperative" "Friendly" "Tearful, but in a good mood" "Affect is normal"	*Provider's descriptors of mood:* "Frustrated" "Upset" "Irritable mood, short" "Depressed, angry mood" "Agitated" "Tearful" "Despondent" "Affect is flat"

The OT group notes also assess the client's mood during the meal planning, grocery shopping and cooking groups. The significant aspect of OT's observation of her mood, is that although she was often having ups and downs with maintaining her mood and behavior on the unit, she consistently demonstrated good mood in cooking groups. Out of the seventy OT notes, positive mood was noted consistently for every single group attended. The mostly commonly used terms used by OT to describe her mood were "engaged, cooperative, pleasant and friendly." Out of seventy notes, one document showed the client stated she felt depressed, however the OT still documented her mood as "pleasant."

OT group notes are very concise and limited to a sentence or two due to the volume of notes that are written during groups. They do not contain lengthy quotes but instead they tend to contain strongly descriptive words to make up for their brevity. The notes are meant to describe anything significant that stood out to the OT during group, making it easy to find patterns in the words used to describe this participant's mood, as illustrated in table seven.

Table 7
OT descriptors of client's mood in cooking groups

OT descriptor	**Frequency in data**
Engaged	60/70
Collaborated/Cooperative	32/70
Pleasant	28/70
Friendly/social	9/70
Excited/happy	12/70
Depressed	1/70

The client self-reported a daily numerical rating of her mood on a scale of 1-10 with one being the worst and ten being the best. Data from her daily goal sheets illustrates patterns of more positive moods when she identifies going to cooking group as her daily goal and lower-rated moods when her goals are less specific, such as "just make it through the day" or "have a good day." Table 8 illustrates patterns between mood and each daily goal by showing the frequency of goals, and average mood related to each goal.

Table 8
Patterns between client's mood and goals

Patient-Stated Goal	**Patient-rated Mood (averaged) 1-10**
Go to cooking groups (39)	9.76
Just make it through (21)	6.19
Just get off the unit (8)	7.75
Have a good day/do good (8)	8.25
Hear good news (2)	5.5

Patterns between cooking groups and hygiene

In addition to illustrating patterns on mood, the provider notes also make significant observations regarding the client's hygiene in connection to cooking group. On the days the client attends cooking groups her hygiene is typically noted as good. On the days she stays on the unit her hygiene and mood are both noted to decrease. OT documentation also frequently takes note of the client's hygiene and finds it to be adequate all throughout the group notes. Table nine illustrates the providers' terms used to describe patterns of hygiene and cooking group.

Table 9
Provider descriptors of client hygiene

Hygiene on cooking group days	**Hygiene when staying on the unit**
"Dressed, clean, good eye contact & hygiene" "Good hygiene" "Up and dressed early with good hygiene" "Up and dressed in street clothes" "Up and dressed at the front desk" "Neatly dressed, hair is combed" "Appropriately dressed"	"Slightly unkempt" "Unkempt with decrement in hygiene" "Unkempt" "Dressed in hospital gown, disheveled"

Patterns in data show that both mood and hygiene increase on cooking group days. An increase in mood could lead to better hygiene or vice versa with each potentially impacting the other. Regardless of the reason, data shows that providers continuously assess both mood and hygiene as an indicator of the client's overall progress, well-being and mental health.

A potential reason for consistent good hygiene on cooking group days is that OTs require good hygiene for all group participants. The group guidelines are posted in the kitchen and are reviewed prior to the start of each group. Group members are aware that they are expected to have completed an adequate grooming and hygiene routine including clean clothes before

coming to group. OTs also clarify that participants who repeatedly disregard the guidelines, including hygiene, may be removed from the group. See artifact one, for cooking group guidelines.

Cooking as a goal, intervention, and outcome measure

During the initial surveillance and first read-through of the data, there was no doubt that cooking group was an important theme to the client's recovery process described across all the three data sources. A significant finding however, was that all three data sets had a unique perspective and meaning associated with the client's participation in cooking groups. The client frequently described cooking group as her daily goal and other times as a method for meeting other behavioral goals. OT data described cooking groups as intervention in building skills for the greater goal of independent living. Documentation from the providers tend to describe cooking group as an outcome measure by which to assess her overall recovery process. Table ten illustrates how the client frequently names cooking as her daily goal and also describes it as an intervention for meeting other goals.

Table 10
Client's view of cooking as both a goal and an intervention

Patient-Stated Goal	**What helped me reach my goal?**
Go to cooking groups (39)	Went to cooking group/grocery shopping (22)
Just make it through (21)	Staying in my room/slept/napped (10)
Just get off the unit (8)	Kept Busy (5)
Have a good day/do good (8)	Nothing (2)
Hear good news (2)	Ignore the challenges (1)
	Hear good news (1)
	Help others (1)

OT documentation describes meal planning, grocery shopping and cooking groups as important interventions to build IADL skills necessary for the goal of living independently in the

community. From the OT perspective, cooking groups also serve as a useful context or environment in which to practice IADL interventions. OT data describes the richness and variety of tasks and activities taking place under the context of cooking groups. These include meal planning, organization, principles of health, safety and nutrition, budgeting, community mobility, shopping and building community partnerships.

Table 11
OT interventions occurring within cooking groups

• Budgeting • Meal planning	"Pt. demonstrated good insight and budgeting techniques to independently create a menu using items that were already available in the kitchen."
• Budgeting • Nutrition	"With minimal verbal cues, the patient considered cost and nutrition when selecting grocery items."
• Community navigation • Social interaction	"Pt. successfully navigated a new grocery store location independently by reading signs, and spontaneously approached a store employee for help locating a difficult item."
• Community mobility • Navigation • Problem-solving • Safety in the community	"Pt. required moderate verbal cues to ride the bus to Wal-Mart, due to being very nervous. She had never experienced using a crosswalk, but was educated on how to use and read the signals for safe crossing."
• Community transportation • Navigation • Social skills • Community partnerships	"Pt. rode the bus to the grocery store that will be near her new apartment. She required minimal verbal cues to navigate the bus route, and was nervous about changing buses, but was able to ask the bus driver when she was unsure what to do."
• Hygiene • Safety • Executive function	"Pt. independently followed a complex new recipe using good hygiene and safety with sharps, oven and stove."
• Multi-tasking • Executive function • Social skills	"Pt. completed two recipes with min assist for multi-tasking technique. Pt. was supportive to peers and showed another participant how to operate appliances."

• Community partnerships • Social skills • Coping Skills	"Pt. independently cooked a dessert to take to community peer support group. The patient states she is nervous but appears excited to meet peers in the community. Educated on social skills and etiquette for attending community group."

Provider documentation appears to use the client's participation in cooking groups as an outcome measure of her progress and skills. The data shows the recovery team frequently looking to the client's performance in cooking groups to influence other decisions in her recovery. When the client demonstrates positive behaviors and skills in cooking group the providers use that data to support the idea that the client may be appropriate for a much less restrictive environment than had initially been considered. They then use her continued participation in cooking group to show capability for community integration and readiness for discharge. The following quotes from provider notes illustrate the use of cooking group as an outcome measure:

> "The team discussed allowing her to go to off-grounds to an all-day conference today. Since she has been doing well and having appropriate behaviors with cooking groups and shopping in the community, we are confident she will be able to do so today."
>
> "She has been turned down by five personal care homes. Since she continues to do well with cooking groups and is learning skills in cooking, shopping and riding the bus, we are considering whether she actually needs a personal care home, or if she might be appropriate for independent housing."
>
> "She is excited about the prospect of potentially getting an apartment. Has been working in cooking groups to ride the bus and go shopping in the local area and she has been advocating for herself so we are continuing to move forward with pursuing independent housing."

Finding family and belonging through cooking

The concept of family is not as densely patterned across the data sets as the other themes; however, it appears to be an important concept to the client, pivotal to her recovery and frequently enough mentioned in the client's statements to signal its own theme. Across all three sources of data, the client's statements reveal a traumatic and dysfunctional history with social relationships in general and specifically family. Thus, belonging to a social group and experiencing positive concepts of family represents a significant milestone to the client. Quotes from the client in Table twelve show the progression of how her concept of family and belonging develops through her participation in cooking group.

Table 12
Client's progression to the concept of belonging

"Nobody cares about me. No one wants me."
"My baby and husband in heaven are the only ones who ever loved me. I might as well go and be with them."
"My guardian's no good. She doesn't care about me. I wish I hadn't woken up from my overdose."
"I'm feeling depressed. My family won't have anything to do with me."
"We cooked again today. I cooked a birthday lunch for the OT. She ain't from around here and she never had country cooking. So I cooked her some good country food on her birthday. And we ate it like a little family birthday party."
"We're like a little family. Me and the OTs in cooking group. We all have our jobs to do, we all pitch in and help and then we sit down and eat together just like a family."
"Well, we're cooking again today. I showed them my Mama's secret ingredient for banana pudding. I never told nobody else, it's a family secret."

"Cooking group is my coping skill. Whatever commotion is going on up on the unit, it don't bother me 'cause I know I'm gonna cook some good food and I have my family in cooking group that cares about me. We're like our own little family."
"I'm gonna miss my little family when I get out of here. But I won't be alone. I got (peer support specialist) and the folks at (community support group). I'm gonna cook my banana pudding and bring it to (community support group). I'll be ok."

Barriers and challenges to independent living after institutionalization

It would be difficult to appreciate the significance of the client's successful transition to independent living without understanding the immense barriers and challenges she overcame. The most obvious barrier mentioned across the data was her long-term incarceration. The stigma surrounding her legal history will likely follow her throughout her life and destroyed many of her family and social relationships. Another impact of long-term incarceration was that the patient was unfamiliar with many modern technologies. Prior to incarceration she was from an impoverished, rural area without many modern conveniences. Adding to that the speed with which technology changes over thirty years, the client had a significant challenge in adapting to navigating modern life in an urban city. OT documents describe teaching her many new things including how to operate a microwave, how to use a crosswalk, navigate public transportation, and use a cell-phone. At times her confidence momentarily faltered but she remained willing to learn and her desire to live on her own for the first time in her life appeared to motivate her to tackle new experiences.

As was discussed in the initial impressions of the data, each data source focused on different challenges facing the patient. The provider's notes focused on behavioral barriers to independent living, the OT data focused on functional challenges and deficits with IADL skills,

while the client most frequently described her challenges as being social and related to stigma. See table thirteen for the most frequently identified barriers across the data sets.

Table 13
Barriers described across the data sources

Provider-described barriers	OT-described barriers	Client-described barriers
• Legal history • Behavioral history • External locus of control • Maladaptive coping	• Low confidence (initially) • Difficulty visual scanning • Lack of experience with key IADLs	• Social stigma • Self-stigma • Belief that no one cares • Feelings of worthlessness

The client's challenges were significant and it was the aim of the researcher for the documents to accurately tell the story of how this individual overcame the barriers associated with chronic institutionalization and achieved independent living. It should also be noted that at the time this study was written, the participant had been living successfully in the community for over a year.

Discussion

The purpose of this study was to bring a deeper understanding to one psychiatric client's experience of transitioning to independence after long-term institutionalization and participating in cooking groups. The results provide strong evidence that institutional cooking groups as an intervention can positively impact a client's experience and moreover, can be vital in helping achieve independence. This study fulfilled its intended purpose of bringing a deeper understanding to the participant's experience of transitioning to independence after long-term institutionalization.

This study also illustrated cooking groups as not only a useful intervention in the psychiatric setting, but as an abstract concept that can serve many purposes for different

individuals and contexts. Learning to cook may be an end goal in and of itself, an intervention towards achieving a greater goal, or an outcome measure to assess a person's skills, participation and readiness for discharge to the community. It may also serve as a fitting environment for learning social skills and experiencing cultural or social belonging.

A specific barrier for this individual client was that she had been limited by the label of "institutionalized," and the assumption by herself and others that she was not capable of independent living. Cooking group became a vehicle through which to advocate for her potential and capabilities and was ultimately the factor in convincing the treatment team that she had achieved the skills necessary to seek a meaningful life in the least restrictive environment. According to the data, cooking groups also provided the client with a sense of self-worth and meaning, which motivated her to become actively engaged in her treatment and work with the team to achieve her goals.

From a transformative perspective, this document review gave power and justice to the client by seeking to understand her experience through her words and documents and highlighting her strengths. This case study was also collaborative in nature in that it highlighted three different perspectives throughout the data sets and illustrated how different disciplines collaborated with each other and with the client to help her achieve her goals. It also demonstrates an effective collaboration between the medical model and the recovery model. The medical model is often rejected by OT in favor of holistic models. In this case, the providers effectively used the medical model to treat that client's illness and symptom burden while the OT staff demonstrated principles of recovery model to focus on the patient's skills, strengths and abilities. Each model contributed and collaborated to form an effective team and provide a holistic continuum of care.

Lastly, transformative research is change oriented. This study sought to explore the concept of change and address the stigma of individuals with mental illness – specifically those who have experienced long-term hospitalization, incarceration, or are frequent consumers of mental health services. This study highlights the recovery of one such individual. This study illustrates cooking groups as an effective context for promoting successful community reintegration and in this case was helpful in instilling hope for life outside the hospital for a psychiatric client through learning to navigate and connect with the community. Cooking groups not only helped the client in this study to achieve vital independent living skills, but more importantly created a sense of purpose, meaning and self-worth that helped her stay engaged with her treatment and motivated her to work towards discharging to independent living.

As influential members on multidisciplinary treatment teams, mental health OTs can use data from clients' participation and skill levels in cooking groups as a vital tool to advocate for a transition to the least restrictive environment. Visible, tangible outcomes such as improved mood, hygiene and participation associated with cooking group can help providers and other members of the team assess clients. OTs articulating the more complex performance tasks in cooking groups to the treatment team can help providers recognize a client's potential to achieve a productive and satisfying life and make appropriate decisions regarding treatment and discharge.

Strengths and limitations of the project

There are many strengths in using a retrospective document review design in this case study. The immense number of documents available provided background and context to the case, showed change and development over a period of time and allowed triangulation to occur

between different sources of data. Another strength to using documents alone, is the lack of obtrusiveness and reactivity. Since documents are unobtrusive and non-reactive, they are unaffected by the research process countering any concerns about reflexivity. Documents are also considered "stable," meaning the investigator's presence does not alter what is being studied (Bowen, 2009).

A potential limitation for document review is biased selectivity, in which the documents selected are likely to be aligned with the agenda of the researcher (Bowen, 2009). The researcher attempted to address bias in the selection process by including every document in each data set, versus choosing randomly, or selecting only positive accounts. There was potential bias in the aspect that the researcher had personally provided OT services to the selected client, was familiar with her case, and expected to find evidence supporting cooking groups in the documents. This could also be seen as a strength, as familiarity with the case motivated the researcher to advocate for and tell the story of the client.

Implications for practice

The phenomenon of institutionalization has been well documented in the literature but less has been explored about the process of community reintegration after long-term psychiatric hospitalization. This study highlights an opportunity for OTs to contribute to this gap both in research and as a practice area. In addition to addressing IADL skills required for community transition, OTs must also prepare individuals mentally, emotionally, and socially for successful return to the community. This study is significant to OT practice in that it demonstrates the potentially substantial impact cooking groups can have on individuals with serious mental illness – specifically those who have been institutionalized, or are frequent consumers of mental health services.

According to SAMHSA (2012), the concept of recovery is the central vision to guide mental health practice. OTs are qualified to have a leading role in mental health recovery because of our distinct values of transforming lives through promoting well-being and participation in meaningful roles and occupations (AOTA's Centennial Vision, 2017). The knowledge gained in this study can be used to inform individual treatment plans as well as the development of group programming in mental health institutions to focus on transitional services for clients working towards community discharge. In order to advocate for these services, OTs must document and disseminate the effectiveness of OT transitional services on individuals with chronic mental illness.

OTs also need to understand the significant impact of stigma on individuals with psychiatric and/or justice system histories – and work to instill hope, self-advocacy and self-worth through engagement in meaningful occupation. This study reinforces occupation-centered treatment as an important dimension of the recovery process by illustrating how a client's engagement with meaningful occupation appeared to be interrelated with her recovery process. This study challenges OTs to never underestimate the power of engagement in meaningful, valued, shared occupations as a healing tool to promote recovery to even those who have been deemed unlikely.

Future Research

Mental health research continues to be considered as a priority research area (NIMH, 2020), making it essential for OTs to continue contributing to research in this setting. The five themes in this document review highlighted several strong patterns across the data that could be investigated further with additional methods, specifically the patterns between mood, hygiene,

and participation in cooking group. While the purpose of this study was to examine themes and patterns across the data, further research may be indicated to investigate the correlational relationships between cooking, mood and hygiene – specifically how and why they appear in this study to be connected. The documents used in this study show there is sufficient data on the topic, and illustrate that these themes have important meaning to the client's recovery process warranting further study. While it was only feasible to review the documents for one client in this study, future research could involve an extensive document review including multiple clients in order to gain a broader view of individuals' collective and unique experiences with cooking group and recovery. Recidivism rates could also be investigated in order to understand the rates of individuals' success in remaining independent in the community after participating in cooking groups.

Conclusion

This qualitative within-site case study used retrospective record review to meet two objectives: 1) To describe the impact of OT cooking groups on the experience of one individual's transition to independent living after long-term hospitalization and 2) To understand the unique barriers and challenges facing one individual transitioning from institutionalization to independent community living. The five themes that emerged answered both of the research objectives by describing how cooking groups were related to improved patterns of mood and hygiene, assisted her with setting and achieving her goals, and provided a sense of family. The themes also illustrated her unique challenges and barriers from multiple perspectives. These barriers included her legal and behavioral history, lack of experience with IADL skills, internalized social stigma resulting in self-stigma, low confidence and difficulty with social relationships. The results of the study may help OTs understand the unique challenges

experienced by individuals who are transitioning to independent living after a long-term hospitalization or incarceration, support the use of cooking groups for a wide-range of potential benefits in this setting, and identify potential areas to support other individuals in this process.

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Appendix A: Definitions

Contexts – the physical environments, social relationships, cultural influences, demographics, and interactions that individuals engage in.

Cooking – the practice or skill of preparing food by combining, mixing, and heating ingredients.

Cooking Group Program – in this study refers to an OT program at a psychiatric hospital that includes classes in meal planning, grocery shopping and meal preparation occurring in a peer group setting.

Holistic – addressing the whole person, including their physical, mental, and emotional health, while taking social factors into consideration.

IADLs – Instrumental Activities of Daily Living are activities that are oriented toward interacting with the environment, and are often complex.

Institutionalization – A phenomenon that occurs when individuals spend lengthy time in restricted environments such as prisons or hospitals and are no longer able to engage in meaningful occupations and skills, or live independently in the outside world.

Normative Life Roles – A set of behaviors connected to social norms that allows someone to organize and allocate time for self-care activities, work, play, social activities, leisure, and rest; examples include the roles of student, spouse, worker, or caregiver.

Occupational Performance – the ability to choose, organize, and satisfactorily perform meaningful occupations that are culturally defined and age appropriate for looking after one's self, enjoying life, and contributing to the social and economic fabric of community.

Provider – In this specific study, refers to the Physician, Psychiatrist, and Advanced Practice Registered Nurse (APRN).

Recidivism Rate – the rate at which psychiatric patients return to the hospital after discharge to the community, or other setting.

Recovery Mall – a selection of education, recreational and skills-based classes offered to patients in psychiatric hospital, and is based on the SAMHSA (2013) principles of recovery which guide the recovery model of patient care.

Recovery Model – a holistic, person-centered approach to mental disorders or substance dependence that emphasizes and supports a person's potential for recovery.

Self-Stigma – the process in which a person with a mental health diagnosis becomes aware of public stigma, agrees with those stereotypes and internalizes them by applying them to the self.

Transformative Worldview – a research framework that centers the experiences of marginalized communities, confronts social oppression and empowers individuals.

Treatment Team – in this study, refers to the multidisciplinary team comprised of psychiatry, psychology, pharmacy, nursing, social work, occupational therapy, physical therapy and recreational therapy in a psychiatric hospital.

Appendix B: Artifacts

Artifact 1

OT cooking group guidelines

GUIDELINES FOR A SUCCESSFUL GROUP

(1) Always be SAFETY aware in the kitchen.

- Be mindful of your surroundings when working around oven
  - Use oven mitts when taking items in and out of oven
  - Don't leave plastic utensils or paper on or near oven.
  - Don't leave items on the stovetop unattended.
- Close kitchen cabinets
- Be careful when using sharps for cooking tasks.

(2) Take measures to prevent the spread of germs.

- Be sure to complete your hygiene routine prior to attending group and make sure you are wearing clean clothes.
- Wash hands and wear gloves when preparing food
- Change gloves when soiled.
- Change gloves when handling raw meat.
- Don't eat from containers
- Don't taste test food while prepping it.
- If you have long hair, pull it back so it does not get in food.

(3) Be courteous to your peers.

- Make sure there is enough food for everyone to enjoy a helping.
- Assist with cooking and clean-up.