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Abstract

Although occupation-based practice (OBP) is considered *best practice* within the occupational therapy profession, practitioners continue to have a difficult time actively implementing OBP into treatment. The Accreditation Council for Occupational Therapy Education (ACOTE) standards necessitate the implementation of OBP. Within the literature, there are gaps in the research investigating novice therapists' perceptions of incorporating OBP in practice, especially in the United States. Since children and youth is a rapidly growing area of practice, this study focused on investigating how novice therapists are implementing OBP in pediatric settings. This qualitative study therefore investigated the perceptions of four novice pediatric occupational therapists' preparedness and ability to perform OBP in practice. By following a qualitative methodology, the following four themes emerged from the data: My academic program introduced me to the principles of OBP, but specific types of learning activities solidified my understanding; I generally know what OBP is, and it is important; but can be difficult to describe succinctly to others; The type of setting where I work influences how occupation-based I can be during intervention; and While I have every intention of providing OBP, the cultural environment of the workplace influences my progress. These findings can add an in-depth understanding of the four participants' experiences as they relate to this profession-wide call to action.

Keywords

Occupation, pediatrics, occupation based practice

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ABSTRACT

Although occupation-based practice (OBP) is considered *best practice* within the occupational therapy profession, practitioners continue to have a difficult time actively implementing OBP into treatment. The Accreditation Council for Occupational Therapy Education (ACOTE) standards necessitate the implementation of OBP. Within the literature, there are gaps in the research investigating novice therapists' perceptions of incorporating OBP in practice, especially in the United States. Since children and youth is a rapidly growing area of practice, this study focused on investigating how novice therapists are implementing OBP in pediatric settings. This qualitative study therefore investigated the perceptions of four novice pediatric occupational therapists' preparedness and ability to perform OBP in practice. By following a qualitative methodology, the following four themes emerged from the data: My academic program introduced me to the principles of OBP, but specific types of learning activities solidified my understanding; I generally know what OBP is, and it is important; but can be difficult to describe succinctly to others; The type of setting where I work influences how occupation-based I can be during intervention; and While I have every intention of providing OBP, the cultural environment of the workplace influences my progress. These findings can add an in-depth understanding of the four participants' experiences as they relate to this profession-wide call to action.

Introduction

Occupation-based practice (OBP) is presently considered best practice and is essential to incorporate throughout the occupational therapy process (Hess-April et al., 2017). The American Occupational Therapy Association (AOTA) described the process of implementing OBP as inherently client centered, which allows for choice, influence and power shared between the occupational therapist and the client. At the 2016 AOTA national conference, past AOTA President Amy Lamb emphasized the profound need for OBP to be inserted throughout the occupational therapy process in order to highlight the distinct value of occupational therapy as compared to other professions.

To understand the term occupation, it is critical to look at the many definitions presented across literature. It is first important to differentiate between occupation, activities, and interventions to support occupation as defined by AOTA (2020). Occupation refers to the broad and specific daily life events that are unique, personalized, and meaningful to clients (AOTA, 2020). Activities embedded within occupations provide a context for deeper understanding, active engagement by the person, and are observed by others (AOTA, 2020). Interventions to support occupations (previously referred to as preparatory methods) are methods and tasks that support occupational performance (AOTA, 2020). Schell et al. (2014) described occupations as both meaningful and purposeful things that people do that occupy their time. Adding to this definition, occupations are unique to each individual and therefore provide personal satisfaction and fulfillment resulting in engagement (Hinojosa & Blount, 2009).

Although the Accreditation Council for Occupational Therapy Education (ACOTE) standards place a great deal of importance on occupation, studies show that the emphasis of occupation in practice is not always illustrated (Andonian, 2017; Colaianni & Provident, 2010; Di Tommasso et al., 2016; Krishnagiri et al., 2017). Findings indicate teaching methods regarding OBP tend to be broad and not well understood (Copley et al., 2010). Additionally, occupational therapy practitioners have difficulty actively utilizing occupation-based assessments during the evaluation phase of the occupational therapy process (Grice, 2015; Krishnagiri et al., 2017). Researchers found that one of the main reasons why occupational therapists may not utilize occupation-based assessments is due to lack of knowledge and education about these types of assessments (Grice, 2015; Krishnagiri et al., 2017). Therapists expressed that broadening and augmenting their education to include more information on OBP would increase their use of OBP throughout the occupational therapy process (Colaianni & Provident, 2010; Grice, 2015).

A qualitative pilot study conducted by Di Tommasso et al. (2016) presented the perceptions of six female and two male occupational therapy practitioners regarding occupation via open and closed-ended questions about their work experience, which ranged from one to six years in the field. The participants did not feel confident enough with their educational experiences to implement occupation into practice due to their initial introduction of this topic while in school (Di Tommaso et al., 2016). They felt their lecturers either deemphasized the significance of OBP or left them with mixed messages regarding the overall concept of occupation (Di Tommaso et al., 2016).

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According to one of the participants, although the professors discussed occupation extensively, their teachings were unsuccessful in addressing the skills necessary to implement this learning when in practice. Participants expressed that confusion resulted from not knowing what constitutes OBP because there was not enough emphasis on incorporating occupation in the service delivery process (Di Tommaso et al., 2016).

Estes and Pierce (2012) utilized qualitative methods to examine the perspectives of pediatric occupational therapists on OBP at medical facilities (inpatient and outpatient) in the Midwestern United States. The participants consisted of eighteen females and four males with experience ranging from one to 35 years of practice. Data was collected via semi structured interviews and then analyzed using a grounded theory framework. The findings emphasized the participants' beliefs that it was necessary to implement OBP to maintain a professional identity. Additionally, participants felt OBP was more effective and more enjoyable to implement during intervention. The participants' use of OBP was dependent upon their occupational therapy education, as well as available time in their day, noting time constraints as a barrier to implementing OBP (Estes & Pierce, 2012),

Hess-April et al. (2017) conducted a study, using qualitative methodology, to learn how four occupational therapists working in a hospital setting perceived OBP. The participants described their education preparedness strengthened their clinical reasoning skills to facilitate occupation-based treatment. Similar to Hess-April et al. (2017), other studies (Andonian, 2017; Colaianni & Provident, 2010; Copley et al., 2010; Di Tommasso et al., 2016; Krishnagiri et al., 2017) discuss the connection of how education programs initially introduce and reinforce OBP may support or hinder this carry over into practice. These studies highlighted positive academic experiences such as embracing practice models that focus on the construct of occupation, pursuing placement in fieldwork settings with an occupation-based focus and using clear definitions and examples to understand the theoretical constructs related to occupation, purposeful activity, and activity.

It is well-documented that students, new graduates, and experienced occupational therapy practitioners from the United States, as well as Australia, described using OBP as beneficial to clients (Colaianni & Provident, 2010; Di Tommaso et al., 2016; Estes & Pierce, 2012; Grice, 2015; Wallingford & Knecht-Sabres, 2016; Wong & Fisher, 2015). However, occupational therapy practitioners reported a variety of internal and external barriers that hindered their ability to implement these methods during occupational therapy services. Collectively, barriers included the therapist's value system, preexisting habits, environments where intervention takes place, and limited time and resources (Colaianni & Provident, 2010; Di Tommaso et al., 2016; Eschenfelder, 2005; Estes & Pierce, 2012; Grice, 2015; Nayar et al., 2013; Wong & Fisher, 2015).

Researchers have investigated OBP and its implementation in varying degrees across practice settings and by professionals with differing years of experience (Estes & Pierce, 2012; Fischer, 2013; Grice, 2015; Hess-April et al., 2017; Mulligan et al., 2014). A growing body of research (Cahill et al., 2020; Little et al., 2018; Pfeiffer et al., 2018;

Scurlock, 2015; Tokolahi et al., 2013) places emphasis on OBP in pediatrics. For example, Tokolahi et al. (2013) found an occupation-based group for children with anxiety to be a beneficial intervention. Pfeiffer et al. (2018) completed a systematic review to determine that occupation-based interventions were beneficial in improving self-regulation for children and youth who had difficulties with integrating and processing sensory information. Meanwhile Estes and Pierce (2012) examined pediatric occupational therapists' perceptions of the use of OBP during intervention. AOTA (2017) acknowledged children and youth as a current key practice area to focus on to highlight the field of occupational therapy into the 21st century. Upon exploring this topic in the literature, there appears to be limited research pertaining to novice therapists' use of occupation- based intervention, particularly in the area of pediatrics.

A growing body of literature (Fitzpatrick & Gropshover, 2016; Gray et al., 2012; Hodgetts et al., 2007; Mitchell & Unsworth, 2005; Oven, 2016; Rotella & Smith, 2020; Šuc et al., 2020; Unsworth, 2001) distinguishes the characteristics of a novice and expert occupational therapist. Some of these studies (Fitzpatrick & Gropshover, 2016; Gray et al., 2012; Hodgetts et al., 2007; Unsworth, 2001) describe the transition from novice to expert in more abstract terms (i.e., professional experience, level of confidence, communication skills). Other studies (Hodgetts et al., 2007; Rotella & Smith, 2020; Unsworth, 2005) outline varied ranges when distinguishing the years of practice between a novice and expert occupational therapist. When utilizing time as a benchmark, researchers agree that a novice therapist can be identified starting at graduation but the time it takes to transition to expert then varies in range from 18 months, 2 years, and to up to 5 years (Hodgetts et al., 2007; Rotella & Smith, 2020; Unsworth, 2005). This current study targets novice occupational therapists as the population of interest; identifying novice therapists by time spent in practice (0-5 years). Due to limited research in this area and calls to action by the profession leaders, the following research question was investigated: What are the perceptions of novice occupational therapists' preparedness and ability to perform OBP in clinical practice?

Methods

A descriptive, qualitative design was the best fit for this research question, as the participants embodied unique experiences, perspectives, and beliefs. This study utilized this line of inquiry to uncover a deeper meaning of occupation. Upon Institutional Review Board (IRB) approval, four occupational therapy students conducted this study as partial fulfillment of their master's degree under the direction of a seasoned qualitative researcher. Following the principles of qualitative tradition, purposeful sampling, which involved deliberately selecting participants on the basis of already defined criteria, was utilized during the recruitment process (Bogdan & Biklen,1998).

Two separate gatekeepers notified novice pediatric occupational therapists about this research study. Both gatekeepers were experienced occupational therapists who had contacts in the field of pediatric practice and could share initial details of this study with recent graduates. After the first two participants consented to participate in the study, recruitment continued with snowball sampling. Snowball sampling allowed participants to recommend others who meet participant criteria (DePoy & Gitlin, 2016).

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Each of the interested participants met with one of the four researchers for an initial meeting to discuss the purpose of the study. During this meeting, the three basic ethical considerations of the involvement of human participants were explained to participants: full disclosure, confidentiality, and voluntary participation (DePoy & Gitlin, 2016). The four participants were recruited from various pediatric occupational therapy settings (i.e., schools, community-based, outpatient, inpatient), who had master's degrees from different accredited graduate occupational therapy schools. Please see Table 1 for a summary of the participants' information. Pseudonyms were used for all names and other identifying information to ensure confidentiality. Once recruited, each researcher then worked exclusively with one participant in terms of data collection. Establishing a direct relationship with only one participant per researcher allowed researchers to conduct an in-depth exploration of the participants' experiences and therefore obtain meaningful information.

Table 1

Demographics of Research Participants

Pseudonym[a]	Age	University[b]	Years post school[c]	Workplace setting	Years of practice
Kate	29	North East/ Public	4	Hospital-run outpatient program & EI[f]	4 & 1
Sue	26	North East/ Private	2	Community-based & school	2
Rachael	33	West/ Public	1	School-based	<1
Eva	25	North East/ Private	2	Privately-run outpatient clinic	1.5

Notes. All participants were novice pediatric occupational therapists (0-5 years of practice). All participants identified as female.
[a]Each participant was giving a specific pseudonym to keep identity confidential.
[b]Type of university/region attended for specific occupational therapy program.
[c]Time since graduating specific occupational therapy program.
[d]Current setting of occupational therapy practice.
[e]Years of practice at current workplace setting.
[f](Early Intervention)

Data Collection and Analysis

In qualitative research, data analysis is concurrent with data collection and helps to guide future interviews (Ely et al.,1997). The method of data collection was the in-depth interview. According to Spradley (1979), a researcher has two main tasks during the interview process: developing rapport and eliciting information. Spradley proposed that a researcher facilitates the process of rapport building by making repeated explanations, asking for examples, and restating what the person says to express interest.

For this study, the researchers used a semi-structured interview format to create a balance between structured and open-ended questions. Semi-structured interviews consist of several predetermined questions to help guide the beginning conversation, but with this design, there is also room for divergence from those questions to elicit more in-depth responses. General or grand tour questions help to increase the participant's comfort level with the interview process (Lincoln & Guba, 1985; Spradley, 1979). What are current and past occupational therapy experiences of pediatric occupational therapists was an example of a grand tour question used for this study.

The preliminary results of those general explorations developed into sub-questions guiding specific inquiries about our participants' perceptions of OBP and how it connected to their educational experiences and intervention choices (DePoy & Gitlin, 2016). Each researcher ranged between 3.5 to 6 hours of interview time with each participant over three or four interview sessions. These sessions also included time for at least two participant checks to clarify information and review the actual interview transcripts. The overall length of each individual interview varied depending on scheduling concerns of participants and the depth of their experiences on a certain topic. Each researcher structured the interviews around these questions: What led you to decide to become an occupational therapist? Tell me about your educational background, including fieldwork experiences. What are the strengths and challenges of working at your job? Describe your view of OBP occurring at your workplace. What factors influence your ability to provide OBP in your pediatric setting?

The researchers followed the coding process outlined by Ely and colleagues (1997) to identify categories and themes. Coding systems are created to organize the data while looking for patterns and intricacies that stood out; these may be certain words or phrases, patterns of behavior, subjects, perceptions, or repetition of responses (Bogdan & Biklen, 1998). The purpose of categories is to organize the initial codes in order to formulate meaning within the codes and integrate how all information may be linked (Ely et al.,1991).

Each researcher who completed and recorded the interview, also transcribed verbatim. Tentative categories emerged from the data, as the researchers began writing relevant words or phrases in the margins of the interview transcripts. The researchers met as a group after their individual coding and read one another's transcripts and analytic memos to complete the next round of tentative coding.

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Based on the transcription logs and audit trails, the creation of analytic memos provide the researchers with an outlet to think through the data gathered and analyze smaller chunks of data (Bogdan & Biklen, 1998). Multiple categories emerged after many reviews, re-reads, and analyses. After successive rounds of coding and categorizing, potential theme statements began to emerge from the data analysis process. These theme statements, based on repeated patterns in the data, captured the essence of the research findings. Please see Appendix for a sampling of the data analysis process.

A researchers' analysis becomes trustworthy or credible when the sources of data capture the essence of those being studied (Bogdan & Biklen,1998; Ely et al.,1997). In this study, support groups, peer debriefing and frequent participant checks addressed trustworthiness. The support group involved weekly meetings with all the researchers and advisor to review the data, address assumptions or bias in the analysis process, and create a detailed audit trail. Within these support group meetings, the peer debriefing process occurred as the researchers read each other's transcripts, analytic memos and categories to consider emerging themes from all possible angles. Each researcher reading all of the transcripts also helped to shape the subsequent interview sessions. It was equally important to conduct frequent participant checks to determine if selected hunches or interpretations made during analysis were accurate. Approximately two - three informal and formal participant checks occurred throughout the data collection and analysis process. Participants received copies of their transcripts to clarify viewpoints.

Results

Four themes emerged from the data.

Theme 1: My Academic Program Introduced me to the Principles of OBP, but Specific Types of Learning Activities Solidified my Understanding

While all the participants attended different academic institutions for occupational therapy study and felt that OBP was integrated throughout their learning, each one identified specific professors, methods, and courses as most impactful in solidifying their understanding of occupation.

> I remember, distinctly, that one professor would have us watch videos on YouTube. One was a video showing an occupational therapist using reachers, pegs, and cones. My professor stopped the video, and we had a group discussion about what OT is and isn't. I remember peg boards and cones weren't even in our university clinic. (Sue)

Eva and Kate recalled a specific instructor that emphasized the concept of occupation-based practice:

> My professors were very keen on "patient first". We often had case studies for many classes, and they came with some background information on the hypothetical client. The students tried to figure out - was it really meaningful to

> the client? Was it something you thought was important as the clinician? If we did not take the client's occupation into consideration, then we were told to redo the assignment. (Eva)

> My professor highly stressed the importance of a top-down approach to care and frequently used the person, occupation, environment constructs which was central in shaping my understanding of this dynamic relationship and must be considered to provide occupation-based care. We were given opportunities to apply these concepts to case studies/assignments in and out of the classroom. Our professor didn't just grade assignments—she provided valuable feedback, asked questions, encouraged us to reflect and always challenged us to dig deeper. This class had a big role in terms of how I choose to provide care now and what I consider to be quality care. (Kate)

Rachael and Sue shared the experience of classes that shaped her perception of OBP and the benefit the class had on her future practice:

> Our teachers really focused on giving us lots of readings that would influence occupation in practice. Specific treatment/interventions was not taught in class. The class set-up gave us plenty of opportunity to really pick apart our readings in small and large groups, make connections, and ask questions. As a result, the effectiveness of meaningful everyday occupation definitely made its mark by the time I finished graduate school. (Rachael)

> My classes emphasized community-based learning to see all different socioeconomic levels within different environments. We had a lot of ties with populations like the homeless, veterans, and mental health. We learned how to do an analysis of what's important for the clients in each setting and how to pick meaningful activities. The teachers made us do reflections, which really helped to open my eyes as how to provide occupation-based care; seeing how diverse OT could be. But I'm not sure that all schools do that, which I think really impacted me because I'm able to see OT everywhere, not just in an outpatient clinic, or a hospital setting. (Sue)

While academic coursework laid the foundation for OBP, all participants described facets of their fieldwork experiences further solidified their understanding of OBP**.**

> My first level 1 and level 2 were at the same skilled nursing facility with the same fieldwork educator. She was a great mentor and really occupation focused. She helped me put a lot more emphasis on occupation, whereas there are the other OTs there batting with the balloons and doing the upper body weights. I spent more time in the 'OT apartment' with clients cooking, changing sheets, and doing showers than I spent in the gym. I feel that experience really supported what I learned in school. (Rachael)

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> Even in the hospital setting, we would go in and we have to get them out of bed that day. We can ask them to wash their hair and they get so excited [so this is how we] turn it into occupation-based and get what you need to get out of it. One of my supervisors, in a geriatric community center, was really big on talking to the clients and figuring out their goals and what is meaningful to them. He would say, 'I don't want you guys coming up with some grand plan and have it mean nothing. (Eva)

Kate also mentioned that her fieldwork experiences reinforced what she learned throughout her coursework:

> I am lucky to have experienced different facilities and settings with some occupation-based care or at least attempts at it. I think it just comes down to seeing what an individual therapist can do in terms of maximizing the occupation-based care that they gave, despite the restrictions that exist within that physical environment. (Kate)

Sue described her two fieldwork experiences very differently from each other based on the restrictions of a hospital vs. a community-based setting.

> There are requirements from the hospital about what needs to be done, productivity rates, how many people you have to see, how long you have to see them before they are discharged, which was like twice. It was a lot more difficult to be occupation-based. A lot of it was just requirements based on the hospital and your role within the hospital. (Sue)

> There aren't too many restrictions or roles [at the community-based setting], and you're able to get a full occupational profile of the client. At community-based settings, you see the kids once or twice a week and you can work on these goals and the different areas you are focusing on. (Sue)

Theme 2: I Generally Know What OBP is, and it is Important; But Can be Difficult to Describe Succinctly to Others

Despite the positive experiences in the classroom and fieldwork, the participants had difficulty or were unable to provide a succinct and clear definition of OBP. Observer comments made in the transcripts highlighted pauses and hesitation throughout all participant responses, especially when compared to other questions posed. Universally, all participants provided drawn out and indecisive answers filled with examples and personal experiences as opposed to a succinct definition prompting specific participant checks for clarity. However, although scattered throughout the transcripts, all four participants used many of the characteristics in line with AOTA's official position such as client centeredness, use of valued occupations, and environmental considerations. Kate explained:

> Working with a family, child, patient, or client to help them become as independent as possible in the roles, routines, and occupations that are most meaningful to them related to home, community, school, and with their family and friends. (Kate)

She elaborated that OBP is, "helping make sure that the treatment is within as natural of a context as possible and incorporating their physical, social, and cultural environments. Treatment is not occupation-based unless you are in the client's community, practicing on their street with their friends, or part of a community-based program."

Initially, Sue expressed she had difficulty verbalizing OBP into words. She said, "It's a hard thing to explain. It's a very hard thing to explain, it's very abstract. Something that's so important, not many people know about it." However, with more prompting Sue said,

> [OBP] is so individualized for each person and it's not a cookie-cutter approach. I'm very holistic and very occupation-based, so depending on the child, it's going to be different. [It's] finding what is meaningful and motivating for the child, what is functional for them in their everyday life. It can be when they get up in the morning, what they do in daily routines, but it can also be something you do for fun like going to a dance. (Sue)

Similarly, Rachael stated, "Your goals would relate to occupation. I think occupation-based practice is really centered around the person and their goals and desires in the correct environment."

When Eva spoke of "best practice" she described it similarly to the other three participants: mentioning factors such as client centeredness and meaningfulness. She did not include intervention taking place in the naturalistic environment as a key factor in her definition; she stated that what is done during intervention should instead carry-over to the natural environment.

> Using whatever the client finds most important in their life and what they're having trouble with now and getting to a point where they can functionally complete those tasks. Also making sure that it is client-first, meaningful, and will eventually carry over to the naturalistic setting. (Eva)

Eva conceptualized the process slightly different from the other participants. She viewed purposeful activities to be "meaningful to the family, child, or caregiver." But she saw occupation a little differently: "When I think of an occupation, like emotional control or reading a person's social cues, that's a huge occupation the parents want for their child." She added, "the child might not find that meaningful" but the session can still be occupation-based."

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Theme 3: The Type of Setting Where I Work Influences How Occupation-Based I Can be During Intervention

All four therapists supported the notion that their workplace setting could help or hinder how much OBP would occur. Two participants, Rachael and Kate, stated that it was easier to conduct OBP intervention in a person's naturalistic setting:

> I'm in the school and in the child's natural environment with them. I get to see something that nobody else gets to see through an OT lens. I can meet them in gym class, in the cafeteria, and in the classroom. I have kids that I would meet in the cafeteria if we have goals to carry their lunch tray independently. We're in the exact setting we need to be in. We're carrying the exact amount of weight on the exact tray they need to carry. (Rachael)

Kate concurred:

> I do not think there are many barriers [to OBP] because you are in the family's home, in the natural environment. I am working with the child, their family or even their dog might be in the picture. For example, I arrive, and it is their breakfast time, so I am able to insert myself in there easily without having to request it. There is a real importance of using what the family has in their home because, if not, when you leave, you're taking the toys that you brought with you. I try to focus on using what the family has in their home. (Kate)

Meanwhile, two therapists specifically highlighted their inability to access a person's naturalistic environment during intervention as a barrier to being occupation-based:

> Going into the home would be so important. There are so many times where I would like to go into my kids' homes and see what the morning routine looks like; it would be beneficial to go see mealtime when these kids are having trouble. (Eva)

> You may not be able to achieve a family-centered goal because you cannot access the family and the client's natural setting; we are not able to go into the community with a lot of our kids. For example, a common goal that we get from families is, 'I want my child to be able to ride a bike with his peers after school'. However, if you're working on this goal in an outpatient setting, you may not necessarily be able to do that. Instead, what we do is more purposeful, like riding the [child's] bike in the hallways of the hospital; and if it's nice out, we can go into the parking lot, but it's just a limitation. (Kate)

The constraints of not being in the client's naturalistic setting during intervention created challenges in which therapists must get creative in order to provide their idea of OBP. As Rachael stated, "I think a lot of people feel limited by the school's physical environment like 'oh we can't do that, we're in the school'. Well, you could, but you have to work a little harder. Another participant, Kate, went into detail on how she tried to compensate in order to provide occupation-based intervention:

> Ideally, you would want to be working with them in their own bedroom getting dressed with their own clothes, but that's not realistic in a hospital setting. I try to simulate as much as possible. I'll have the child bring in their own things and we will establish a consistent routine. I sometimes suggest to families to take pictures of their home or videos of certain routines and how the child is responding within the home. I will use that to give as realistic strategies as I can that they can implement on a daily basis. (Kate)

The participants also explained the availability of products or equipment in a person's physical or non-human environment supports OBP.

> We have a new playground that we got with one of our grants. It's very exciting. We want our kids to have a playground that's typical. A lot of kids had goals like learning how to do the monkey bars and a lot of our kids have hemiplegia so having typical, actual monkey bars out there is so occupation-based. We also have some parts that are accessible for all the other children that may need that so there is something out there for everyone. (Sue)

Just as there were benefits attached to the physical environment, for three of the therapists, the lack of products and equipment in their treatment locations also created obstacles. Factors such as lack of equipment, resources, and treatment space all inhibited occupation-based intervention:

> I would like to provide more occupation-based care, but I don't know how I can do that in the hospital setting. I try my best, but factors like space of the environment can be a barrier, we do not have all of the resources that we need to make it feel like occupation-based – or to even simulate this type of care. [For example] Parents may come with dressing and grooming goals, but we do not have a bedroom. We do have one ADL room that is set up like a kitchen, but other than that, we do not really have any other rooms that allow you to even simulate a home environment. (Kate)

> There are challenges, probably more challenges than strengths. I do not work for the Board of Education, I'm contracted by a company, so because I don't work for the school, the principals do not consider me a priority. I'm an afterthought. In one school I have a room with a microwave, and the teachers come in and out all day, and that's the space that I've been given, the size of a closet too. So, am I doing great occupational therapy? (Rachael)

> I wish that we had a playground out back that we could do more work outside. I think being outside is really important and we can't do it. We can go outside and do bike riding on the sidewalk, but I wish that we had more outdoor play. (Eva)

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Theme 4: While I Have Every Intention of Providing OBP, the Cultural Environment of the Workplace Influences My Progress

All four participants described how workplace culture influenced the type of intervention they provided to the children. While these therapists aspire to provide occupation-based intervention, such factors as the expectations of the workplace could limit or strengthen their intervention approach.

> Certain grooming routines like cutting nails are not possible in an outpatient clinic because of policy. We may see kids that have tactile hypersensitivity, but it is not something that we can work on because it's a safety concern. We can just desensitize them for it and give them strategies to do at home. (Kate)

> In school, I know this one boy who didn't know how to tie his shoes and was really upset about it. It's not on his IEP, so it's not something I can work on. I do a lot of handwriting because that's academic-based. (Sue)

Eva and Kate described workplace expectations such as documentation demands, productivity quotas, and job responsibilities as barriers to OBP. Eva said:

> The amount of hours I work is a negative. It's so time consuming. I was working like 75 hours a week and I was only getting paid for 40 hours. Sometimes it's hard because it's the time that limits you. I always take work home. When I have a huge time, instead of planning, I'm catching up on paperwork. There are so many great activities, but I just wish I had more planning time. (Eva)

> Another big challenge is having to maintain a certain level of productivity to pump out numbers. You need to see a certain amount of goals per week of how many children you see or bill out for each week. When it comes down to it, it is a business. I would say that when I first started working, productivity demands were not as high, and I definitely was able to provide more worksheets, handouts, and training videos- things like that. (Kate)

However, therapists were able to identify aspects of workplace culture that positively aided in the provision of OBP. Sue identified many strengths of working at her community-based setting, particularly surrounding her freedom of choice.

> There is literally everything under the sun that we work on because policy allows us to. Can be anything like riding a bike, hair-tying. One child wanted to work on kayaking, so we actually brought in a kayak and worked on a lot of strengthening of his extremities because he had hemiplegia so just grabbing the ore was difficult. First, we worked on maintaining grasp on the ore and facilitating that motion. We simulated the kayaking a lot before we brought the kayak in. We then actually brought a kayak in, which is helpful because your legs are in a weird, funky position in a kayak. (Sue)

Sue was physically able to go into the child's natural environment when treating at her community-based setting, because it was an expectation. Sue described occupation-based groups that she led in the child's natural environment:

> On Saturday mornings, we do recreational programs for basketball, soccer, tennis, and baseball on the regular fields for kids with special needs. We have high school, middle school kids that are typically developing come too and they are peer models. These [special needs] kids thrive and just want to be a part of a team. We are setting up an environment that's fun, successful, and safe for the kids. The ultimate goal for all these programs is for the child to go into a typical rec league of the town. (Sue)

All therapists were able to identify, in at least one way, how the behavioral standards and coworker relationships that were present in the workplace could serve as an aid as they tried to implement OBP. For all of participants, coworkers, in particular, were a great support system:

> I think the OTs that I work with are very open to bouncing ideas off of each other to make this as occupation-based as possible in this setting. It is nice to have that kind of social network of support to just collaborate with. I think it makes you a better clinician when you can listen to other people's ideas. (Kate)

> We have to meet with our supervisor once a week and we meet for an hour and we go over goals we have written or kids we are having trouble with. Everyone is in the same room, so it's great because we are constantly bouncing ideas off each other. There is a very high standard to be client-centered and even though there is a ton of work, I am very lucky to be there. (Eva)

> I think it is a strength of the job and my coworkers are all really good OTs and I think in any job environment, you have those days where you're like drained and you have somebody there who's like, 'here's this really cool idea' and I think that helps a lot with treatment. Learning all new stuff and just trying to come up with different ways to work with different types of kids. (Rachael)

> At our staff meeting we talk about our clinical stuff. We kind of just like break the activities down- task by task, which is really nice. We all [referring to her coworkers] are very community-based. It's very family-oriented, client-centered, which inspired me, that I was able to help people non-traditionally. (Sue)

Three therapists identified their supervisors as positive influences to their intervention implementation:

> My boss is the one who drives everything. His famous last words are "do whatever you want," because he trusts that we're doing right by our families, our kids, and our profession. It's so nice to have a boss that just really wants what

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> OT really is and isn't just like, ‘oh we are going to do this for money’. We are doing things because that’s what’s right. OBP is really, really ingrained in us here. (Sue)
>
> We have good teamwork. My supervisors are so willing to help with any question you have. I think that is one of the biggest strengths. If we need something, the owners just buy it for us. They are so into the kids, whatever we need, within reason. (Eva)
>
> I think that for someone who is in a supervisor role and is the leader of the department, you definitely set a tone for everything. So we always strive and focus on function and how we can help a child reach their greatest potential in functional participation. (Kate)

Discussion

All of the participants graduated from different occupational therapy programs, yet reported their schooling laid the foundational knowledge for OBP. Each participant highlighted specific activities, assignments, courses, instructors, or fieldwork experiences that had the most profound impact on their integrated learning of OBP. Although the participants perceived OBP as valuable and important, they initially struggled to provide a concise and direct explanation. Each practitioner provided a unique description of the construct, which included many of the characteristics from AOTA’s official definition and 2011 ACOTE standards. The participants identified specific characteristics of OBP were emphasized during academic preparation such as: client-centered; incorporates occupations; meaningfulness to the client; and conducted within the natural environment.

The responses provided by the participants, with regard to both their educational experiences and their perceptions of OBP, directly reflect these ACOTE standards. The integration of ACOTE standards into their academic experiences via coursework, classes, fieldwork, or by a particular professor, made a lasting impact on participants’ current perception of OBP and their drive to utilize it during intervention. While it is not always feasible in practice to implement OBP, all participants indicated that the use of the client-centered approach of OBP motivated clients and improved intervention outcomes. The degree to which an academic program highlights OBP can shape a practitioner’s understanding and facilitation, post-schooling. Similar to our findings, other studies (Andonian, 2017; Di Tommaso et al., 2016; Krishnagiri et al., 2017; Wallingford & Knecht-Sabres, 2016) have also demonstrated the importance of emphasizing OBP during one’s educational experiences.

The participants of the current study were intrinsically motivated to implement OBP and placed high value on implementing OBP in their practice. However, external factors, such as workplace setting and culture, had a large influence on each participant’s ability to provide this type of intervention. According to the participants, the setting influenced whether a therapist implemented intervention that was considered occupation-based, or preparatory (now referred to as interventions to support occupations as per the latest

edition of the Practice Framework). When intervention occurred outside of the client's natural environment, therapists identified that this limited the degree of occupation-based care they could provide. For example, an outpatient facility may not have the physical space to simulate a bathroom, which can potentially limit the carryover of intervention. Similar to this finding, other studies (Colaianni & Provident, 2010; Drolet & Désormeaux-Moreau, 2016; Estes & Pierce, 2012; Krishnagiri et al., 2017; Mahani et al., 2015; Mulligan et al., 2014; Wallingford & Knecht-Sabres, 2016) discussed the value OT's place on OBP even if the actual intervention that is provided does not reflect those core values. These studies highlight the importance that therapists place on OBP, regardless of the intervention setting which was consistent with our current findings.

Upon deeper analysis, the participants additionally stated the cultural expectations in the workplace also influenced the implementation of OBP. Factors, such as: workplace customs, activity patterns, behavioral standards, and expectations, greatly impacted intervention. The participants identified that these factors influenced the goals created and the intervention approach utilized. Participants spoke of non-occupation-based goals in a school system (i.e., creating a train with three blocks vs. a functional goal). Additionally, two of the therapists spoke of increased productivity demands and expectations (i.e., increased documentation and caseloads) as facets of workplace culture that create barriers to OBP.

Daud et al. (2016) conducted a mixed-methods study with 15 seasoned occupational therapy practitioners and educators in Malaysia. They uncovered five categories related to the barriers of implementing OBP such as client factors, occupational therapist factors, contextual factors, occupation as treatment modalities, and logistic issues. As similar to our findings, the therapists identified logistical issues that hindered the ability to pursue OBP that aligned with the perspectives of our participants; the aligned logistical issues include the lack of necessary resources, time, and workload challenges (e.g.: high volumes of clients on their caseloads).

Interestingly, the participants also described positive influences noted within the workplace culture that created more opportunities to provide OBP. One therapist spoke of going into the community with her clients or working on goals, such as kayaking in her clinic, as these behaviors were encouraged by her facility. A supporting aspect of OBP was identified as having access to a client's naturalistic environment during intervention or having areas in the clinic that simulate a natural environment (i.e., kitchens, playgrounds, classrooms etc.).

As similar to our findings, a number of studies explored OBP to more fully understand the barriers of implementation (Colaianni & Provident, 2010; Drolet & Désormeaux-Moreau, 2016; Eschenfelder, 2005; Grice, 2015; Nayar et al., 2013; Skubik-Peplaski et. al. 2015; Wallingford & Knecht-Sabres, 2016, Wong & Fisher, 2015). These other studies did not highlight aspects of a treatment facility's environment that can serve as a support to OBP, making this finding unique to the present study.

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Limitations

There are some notable limitations associated with this study. Four researchers collected data for this study. While each researcher worked exclusively with one participant while conducting the interviews and participant checks this created additional challenges to ensure the data collection process explored similar topics. Trustworthiness was emphasized with frequent peer debriefing meetings and participant checks. However, data saturation was not achieved, as the researchers recruited for convenience rather than when no new information emerged from the interviews. Suggestions for future research include increasing the number of participants, investigating this topic across other settings, and conducting longer interviews to gain greater insight into the use of OBP by novice pediatric occupational therapists.

Implications for Occupational Therapy Education

Students represent our future, and their actions will ultimately drive our profession's priorities and goals. They can lead this charge by creating and sustaining shifts towards the implementation of OBP initially emphasized during academic preparation. Students need to be aware of the potential supports and challenges during their academic preparation, so they can create plans for change while still in school. This awareness begins in the classroom and continues throughout fieldwork and other learning experiences. For example, in collaboration with their supervisor, Level I and/or Level II students can highlight and provide educational awareness of occupation-based approaches to practicing therapists. An example of such collaboration would be to create an annual "Hide the Cones" campaign, where therapists agree to put away cones and other non-purposeful activities from their clinic cabinets and provide occupational based intervention for their clients for a minimum of one month. This act can then be connected with meaningful discussions about the AOTA Choosing Wisely campaign, which recognizes the importance of intervention that is necessary and consistent, to be a catalyst for longer lasting change (Richardson, 2018).

In addition to education, clinical experience, and meaningful collaboration/discussion, educators of entry-level doctoral students should emphasize residency projects that address some facet of occupation-based practice in terms of research investigation, program development, or policy implications. Through both purposeful and comprehensive education, novice therapists will be empowered to create change. By increasing an occupational therapist's self-awareness that a workplace setting and accompanying cultural norms can support or hinder OBP, small changes can result over time. Once this awareness and small change process begins, then more planning will be needed to create a sustaining ripple effect to reach the cultural norms of organizations and systems within which we work.

Conclusion

Molineux (2011) suggests that occupational therapists need to reclaim the profession's identity by infusing occupation into practice. Yet, the research investigating OBP emphasizes experienced therapists in a variety of practice settings or outside the United States altogether. Our study addressed this issue by gaining a deeper understanding of the experiences of novice occupational therapists on their preparedness and ability to

perform OBP in practice. In terms of preparedness, the participants described a solid foundation of academic experiences leading to confidence implementing OBP during employment. However, they identified a number of unexpected factors that supported or hindered the actual implementation of OBP after schooling was completed.

While our findings cannot be generalized to the entire profession, the intent is for the reader to determine the relevancy to their own situations. This study can have implications for occupational therapists beyond novice practitioners including experienced occupational therapists and supervisors working in all practice areas. With the growing concern of professional identity and the push to return to the profession's roots of occupation, the research base regarding this topic needs to increase. The findings of this study only scratched the surface and left the researchers with more questions to explore. Why do therapists struggle to implement occupation-based intervention in a clinical setting originally emphasized during academic preparation? Why do therapists continue to seek job positions within such settings that deemphasize occupation-based intervention?

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Appendix

Sampling of the Data Analysis Process for Theme Two

	Client centeredness	Use of valued occupations	Environmental consideration	Observer comments
Kate	"[play] is a means, and then also is an end goal. But I mean play isn't always (pauses) certain types of play is not always occupation based for a certain child. Every child is different. They have different wants, needs, different likes, different dislikes, so just because I pull out this puzzle from the closet and I give it to this child who hates puzzles (laughter) doesn't mean that it is occupation based, so I don't – like I said, play is very much the biggest occupation of childhood, but we have to be careful in the way that we use play" (Interview 1, page 34, lines 11-16)	"I am always linking it [treatment] to something that the child has trouble with or something that the child strives in related to their home, their community, their school, with their family with their friends, that kind of stuff." (Interview 1, page 24 lines 17-19)	"You have to ask about culture, you have to ask about environment. For example, there as, um one little boy um that a fellow coworker of mine was seeing and um he kept on putting- he had a feeding goal and the parent brought in like a bowl of rice and there was the utensil there, but he just went to go eat with this hands-. So, I saw my coworker and she kept on redirecting him to use a spoon - I was like, "I know that the family is -and of course you shouldn't make any assumptions" ...you know, you also shouldn't make assumptions about a particular culture, but you should ask questions" (Interview 2, page 22 line18-23; page 23 lines 1-12)	*Kate seemed to always present her responses with a sense of familiarity and understanding. This is apparent through her immediate responses/ no hesitation. Additionally, she illustrated her understanding and comfort with concepts through the inclusion of "OT" phrases i.e., client centeredness, occupation, environment when speaking.* *Kate was able to provide a lengthy personal definition, compared to the AOTA definition of OBP and was able to integrate many personal examples and anecdotes to support her definition as opposed to using a clear succinct phraseology.*

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Sue	"it is so individualized for each person, so it's not a cookie cutter approach" (Interview 2, page 1, lines 2-3) "I'll ask them what they like to do. What their interests are like so I can kind of get a feel off of that" (Interview 2, page 3, lines 20-21)	"we look at the whole person. We look at the child, and what they do throughout their day, throughout their life. We look at what you do in your life and if there's any sort of difficulty or dysfunction, we look at that and hone in on that and teach you strategies and practice it because practice makes perfect until you are comfortable or successful in your daily life." (interview 1, page 30, lines 13-19)	"So on Saturday mornings we do basketball, soccer, tennis, and baseball too. All the kids are special needs and what we do is that we have high school, middle school kids that are typically developing. They act as peer models for our kids with special needs and it's just such a great program. So just setting up an environment that's fun, successful and that is safe for the kids is just so rewarding and so nice to see that this is out there in the world and that it's not so shunned or taboo." (Interview1, page 11 , lines 3-11)	*Sue gives an impression of understanding and passion when answering questions, often adding her own emotions (whether frustration or excitement etc.) in her personal anecdotes when discussing OBP.* *Sue struggles to succinctly define the term, at times even saying, "it is abstract and hard". However, she comes across as not only having an understanding of OBP but also an awareness that OBP is something that no other OTs understand or implement correctly.*
Rachel	"Your goals would be related to occupation. I think occupation-based practice is really centered around the client and the client's goals and desires" (interview 2, lines 21-22, page 5; page 6, line 1)." Connection-based practice" (interview 2, lines 21-22, page 8).	"When I write my goals, [I] always connect it to something, even if it's something a little more handwriting-based, specifically so that he can copy his homework assignments off the board in a timely manner. That's something he needs to be able to do in the	"[I'm] in the school, [I'm] in the child's natural environment with them. To be able to function in the classroom or do arts and crafts, you need to be able to operate scissors for all sorts of things, use a pencil, keep yourself organized and just navigate the school, or even me just make suggestions to	*Rachel presents with what appears to be a confident understanding of OBP, showing a considerable level of passion regarding how OBP is used/not used in her setting. Through primary use of examples, she describes different intervention approaches that she finds to be client-centered, to help*

		classroom" (interview 1, lines 4-7, page 39).	the teacher (interview 1, lines 6-17, page 42).	*aid in her definition of OBP.*
Eva	"it's using whatever the client finds most important in their life and that their having trouble with" (interview 2, lines 4-5, page 2)	"occupation-based practice [is helping] our clients [with]their daily things that they are struggling with" (interview 2, lines 20-21, page 2). "on like a dressing goal or some sensory stuff. I remember this one boy- we would practice- getting their church clothes on and doing something fun in his church clothes" (interview 2, lines 8-11, page 4).	"[making sure] will carry over to the naturalistic setting" (interview 2, lines 2-3, page 8). "Some of the stuff we can find a way around but there is definitely a barrier of how much you can go into the real setting." (interview 2, lines 5-6, page 15).	*Initial responses are unclear and disjointed. Not sure if she fully understands question or be secure in her understanding of OBP…. follow up interviews needed* *In follow up interviews and with continued probing, Eva is able to demonstrate a more evident understanding of OBP, however does not provide a succinct definition, instead she uses constant examples in her definition.*

Note. The coding scheme example, presented in this table, illustrates how the participants defined OBP using phrases related to the AOTA official position including constructs of client centeredness, use of valued occupations and environmental considerations. The observer comments highlight the participant's difficulty in clearly defining OBP, but instead use examples and phrases over multiple interviews.

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