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The Influence of Occupational Therapists' Worldview on Clinical Reasoning and Action: A Qualitative Study

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THE INFLUENCE OF OCCUPATIONAL THERAPIST’S WORLDVIEW ON CLINICAL REASONING AND ACTION: A QUALITATIVE STUDY

By

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THESIS

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THE INFLUENCE OF OCCUPATIONAL THERAPIST'S WORLDVIEW ON
CLINICAL REASONING AND ACTION: A QUALITATIVE STUDY

ABSTRACT

This qualitative study examines the influence of occupational therapists’ worldview on clinical reasoning and action. Recent clinical reasoning research has determined that this complex and multi-faceted process is more than applied theory. Some scholars in occupational therapy have identified intrapersonal factors as influencing clinical reasoning. However, the nature and role of the intrapersonal factors in clinical reasoning remains unclear. To increase understanding of this phenomenon, semi-structured interviews were conducted with expert therapists. Results suggest that a therapist’s worldview, specifically related to beliefs about human nature does affect the way they envision and enact the occupational therapy process. This influence is evident as the therapists experienced a blending of personal and professional identities and beliefs in practicing occupational therapy. The initial attraction to occupational therapy, the way each therapist connected with others, the way he or she envisioned the role of occupational therapy, and the personal meaning and satisfaction that resulted from working as an occupational therapist all demonstrated this relationship. Implications for practice, education, and professional development are discussed.
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CHAPTER 1

INTRODUCTION

Personal Experience and Beliefs

I began my journey towards becoming an occupational therapist without really understanding why. From my limited experience in observing occupational therapists’ practice, something within me resonated that what they were doing was valuable, and I wanted to become a part of it. It was, in part, because the profession involved helping others, but so do numerous other professions. So what was it specifically about occupational therapy that resonated with who I was and who I wanted to become?

While still an undergraduate student, I had the opportunity to watch three experienced therapists all working in the same setting with the same client group. But despite the homogeneous nature of the context, each therapist seemed to go about the therapy process in a unique manner. This uniqueness included the approach they took when interacting with clients, the interventions they used to enable clients, and what they emphasized in treatment. From an outsider’s perspective there seemed to be a continuity between who each therapist was as a person and who he or she was as a professional. Each therapist seemed to be performing his or her professional practice in a manner that was an extension of who she or he was. Perhaps the reason that the individual therapists assemble the occupational therapy process differently is because their thinking processes may be related to the meaning making systems they use.
In any reasoning process the basic assumptions or presuppositions one holds are important because they form the meaning making system for our thoughts (Mezirow, 1990). The interconnected system of beliefs that forms an individual’s understanding about the world and the way it works or should work is called a worldview (Nash, 1992; Stevenson & Haberman, 1998). A Notre Dame philosopher, Thomas Morris (1987), explains worldview beliefs by saying, “they are not usually consciously entertained but rather function as the perspective from which an individual sees and interprets both the events for his own life and the various circumstances of the world around him” (p. 22). Without some presuppositions we would have not basis to understand the world around us (Sire, 1980). The result of this individualized and often unconscious worldview is a uniquely differing view about what we ought to do, the manner in which we should do it, and the actions we select (Stevenson & Haberman, 1998).

As an evangelical Christian I have a worldview with specific beliefs about God, reality, the nature of knowledge, morality, and humankind. These foundational beliefs influence the way I live my life, interact with others, and the daily decisions that I make. Additionally, my worldview influences the way I experience the world I live in, to what I attribute the causality of what occurs, and even the thing to which my attention is drawn in observing the world. I now see the tacit connection I felt with occupational therapy was what I perceived as its potential as a context to live out my worldview about what is important in life.

My worldview involves a view of the human as physical, emotional, and spiritual in nature, and that we have interconnected needs in all of these dimensions. Researchers have demonstrated that the body and mind are intimately connected at the cellular level
with physical links between emotions, attitudes, the central nervous system and the immune system (Farrar, 2001; Pert, 1993). This connectedness has been referred to as the mind-brain-body connection, and has been “long recognized as the key to physical and mental health and well being” (Hammell, 2001, p 187). Occupational therapy as a profession seeks to address individual’s needs in a humanistic, holistic, and client centered manner (Findlay, 2001; Hagedorn, 1995; Hammell, 2001). This pragmatist view of the human rejects anything that “sublimated people to anything less than their total experience” (Hooper & Wood, 2002). The Canadian Association of Occupational Therapists (1997) explains this total experience by suggesting that humans possess a higher self which is “uniquely and truly human” and which “we express in all of our actions” (p. 42). It is my belief that this interwoven nature of spirit and body results in setting humans apart as having a uniquely spiritual essence. I agree with Egan and Delaat (1994) that “a person’s spirit in not only a part of a person, but rather “the core characteristic that defines the person” (p. 96). The value and total experience we posses is encompassed by this innate spiritual essence. As a result I consider all humans as having equal inherent value regardless or their situation or circumstance. Miller (2002) in a discussion of the impact of worldview states, “ideas have consequences. They demand decision-making and action. The way we view the world determines how we treat it, and specifically, how we treat those in our care” (p. 8). Therefore, because of my worldview, how I will think about and interact with clients and express myself as a professional in the field of occupational therapy will be unique.

As an occupational therapy student completing fieldwork, my worldview influenced my clinical reasoning and actions in practice. For example at a long-term care
facility I had the opportunity to interact with an elderly gentleman who had suffered a stroke. The stroke had severely impaired the individual’s ability to verbally communicate and perform functional tasks. During therapy one day this client became visibly upset. By communicating through gestures and the few intelligible words he was able to whisper it was discovered that his family, because of his limitations, had been interacting with him in way which he interpreted as condescending. This made him feel like he was worthless. My clinical reasoning process was influenced by this discovery. I felt that it was necessary to show his family members both verbally and through my interactions with the client the value that he still possessed as a human. Specifically, I integrated this into treatment by emphasizing the abilities he still possessed, by including him in all choices concerning his treatment, and by talking through him rather than about him to other staff and family members. I saw my interactions as explaining that this patient’s essence or spirit had not changed because of his limitations. Only his physical abilities to express that essence had changed. By relating to him in this manner, I hoped to demonstrate a respect and appreciation of his spirit and the innate value that he posses. It is my belief that as I enter the profession of occupational therapy my worldview beliefs will continue to influence the way I conduct the clinical reasoning process.

**Background**

Clinical reasoning is the thought process that underlies the occupational therapy process and has been established as the foundation of professional practice (Benamy, 1996; Higgs & Jones, 1995). According to Higgs and Jones (1995) “in the absence of sound clinical reasoning, clinical practice becomes a technical operation requiring
direction from an outside decision maker (xiiv).” In order to have legitimacy as a profession, occupational therapists must be able to articulate the value of what they do.

Occupational therapy’s initial attempt to articulate its clinical reasoning was influenced by a rational model of cognitive processing that is at the heart of the scientific method. In this model, professionals could solve the problems facing their professions using causal relationship to applying theory to practice. This type of clinical reasoning based in scientific inquiry was seen as one way to increase the professional image and credibility of occupational therapy (Parham, 1987; Yerxa, 1991). However, scientific rationality has proven inadequate as the sole approach to clinical reasoning. Grounding in theory does not assure expert practice, because while theory gives general principles, “the uniqueness of each clinical situation requires judgment and improvisation” (Mattingly 1991, p. 982). This idea is echoed by Schon (1987) in a discussion of professional reasoning when he said, “most real world problems do not present themselves as well-formed structures, but rather as messy, indeterminate situations” (p. 4).

This is especially true in the field of occupational therapy where clinical reasoning is primarily directed not to the biological disease process but, “to the human world of motives and values and beliefs-a world of human meaning” (Mattingly, 1991; p. 983). Therefore the medical model, with its focus on diagnosis, proves to be inadequate as an explanation of the thinking process that occupational therapists utilize in practice (Fleming, 1991; Higgs & Jones, 1995).

In an attempt to facilitate a more complete understanding of clinical reasoning related to occupational therapy the American Occupational Therapy Association and the American Occupational Therapy Federation (AOTA/AOTF) jointly commissioned a
clinical reasoning study. The principle researchers found that in fact no one form of
clinical reasoning was adequate to describe how therapist’s employ clinical reasoning in
practice (Mattingly & Fleming, 1993). Instead, the study identified four divergent and
integrated types of clinical reasoning that therapists implement in the occupational
therapy process. These divergent types of reasoning are necessary because therapists
simultaneously consider the contextual issues affecting the patient now and in the future
related to their illness or injury, the culture of the practice environment, the interpersonal
relationship between client and therapist, and even the personal values of the therapists
(Schell & Cervo, 1993).

The complexity of decision making required to apply the widely dispersed
knowledge base that underlies occupational therapy requires therapists to render personal
value judgments to choose among equally valid options (Fleming, 1991; Neuhaus, 1988;
Peloquin, 1994; Rogers, 1983; Schell & Cervero, 1993). For this study, I propose these
value judgments are informed in part by a therapist’s meaning making system or
“worldview.”

Research Questions

From the therapists point of view how does their worldview influence their
professional practice? How do therapists perceive and describe the link between their
worldview and clinical practice?

Purpose of the Study

The purpose of this study is to examine how occupational therapists experience
the relationship between their foundational philosophical beliefs or worldview and the
clinical reasoning and actions they utilize in practice.
A review of current literature in occupational therapy suggests that intrapersonal factors such as beliefs and values that a therapist holds have an influence on the clinical reasoning process. However, the degree of influence these intrapersonal factors hold has not been researched adequately, specifically related to therapists’ perceptions of the relationship between foundational worldview beliefs and clinical reasoning. Therefore, through a qualitative process, a more complete understanding of how therapists make clinical decisions will be gained. This study will utilize semi-structured interview and qualitative analysis to explore how occupational therapists experience the link between their views of the world and how they enact clinical practice as professionals.

Need/Significance of the Study

A better and more complete understanding of the clinical reasoning of occupational therapy is essential for professional growth and survival (Barnitt, 1990; Leicht & Dickerson, 2001). The difficulty in observing and evaluating clinical reasoning in occupational therapy has lead patients, family members, other health care professionals, and third party payers to underestimate the value of occupational therapy and to simply dismiss it as common sense (Benamy, 1996). "If the profession is ever to establish a sound rationale for the unique way in which occupational therapists give meaning to the therapeutic experience, each clinician must achieve an understanding of the relationship between actions and their underlying clinical reasoning" (Munroe, 1996, p. 106). Rogers (1983) claimed that "our failure to study the process of knowing and understanding that underlies practice precludes an adequate description of clinical reasoning, which in turn prevents the development of a methodology for systematically improving it" (p. 602). By explicating another tacit element of what we do as
occupational therapists, we will greatly enhance the credibility of the profession and will also aid therapists in being able to articulate what it is that they do and why it is valuable to their clients. In addition examination of how therapists think will lead to a better understanding of occupational therapy process and will aid in educating future occupational therapists (Burke & Depoy, 1991).

There is also potential to improve the quality of service that occupational therapists are delivering by linking the therapist’s own meaning to their daily work. This linking may also assist the field of occupational therapy in retaining therapists who are currently leaving the field because they feel that they are not able to practice occupational therapy in the manner that initially attracted them to the profession.
Clinical reasoning in occupational therapy involves balancing and prioritizing a number of contextual, interpersonal, theoretical, and intrapersonal factors. It has also established in literature that there is no single right answer to the problems with which professionals deal (Hagedorn, 1997; Schon, 1987). For while there may be things that are clearly inappropriate in clinical treatment, several treatment options remain (Hagedorn, 1997). Leicht and Dickerson (2001) suggest that in occupational therapy, as in other professions, the ability to identify “the crucial problems to solve in the face of the complexities and multiple uncertainties of clinical practice” is what distinguishes the expert practitioner from other professionals in the field (p.122).

Clinical reasoning may be the singularly most important aspect of clinical practice. Through the clinical reasoning process occupational therapist’s must make decisions about what to assess, which problems to treat, what goals to set, what interventions to use in reaching those goals, how to motivate clients, when to revise or alter the treatment plan, when to discharge clients, and where to discharge clients all within the constraint of the practice setting (Depoy, 1990; Mattingly & Fleming, 1994). The complexity inherent in the clinical reasoning process requires a combination of technical skills and personal and professional knowledge that integrates “all of a
therapist’s academic training, philosophical beliefs and values, and professional as well as personal life experiences (Benamy, 1996, p. 2). In an attempt to create the necessary background for the current research, literature will be reviewed for definitions of clinical reasoning, the suggested types of clinical reasoning therapist use in clinical practice, and the internal and external influences on a therapist’s reasoning. This will provide a basis for understanding the gap that exists in occupational therapy between the research of clinical reasoning, and how therapist’s perform clinical reasoning in practice (Benamy, 1996; Mattingly, 1991). Following this review, professional literature in the fields of nursing (Smith & Godfrey, 2002), education (Combs, 1982; Dirkx, Amey, & Haston, 1999; Dirx & Spurgin, 1992; Kagan, 1992), and rehabilitation counseling (Corey & Corey 1998; Emener, 1997; Emener & Ferrandino, 1983; Nowlin & Blackburn, 1995; Phemister, 2001) will be examined to determine how other professions have filled this gap. Finally a possible conceptual basis for how therapists construct the clinical reasoning and action related to their worldview will be proposed.

Defining Clinical Reasoning

Broadly, clinical reasoning refers to thinking and decision making process that a therapist utilizes in practice (Strong, Dilbert, Cassidy & Bennett, 1995). More specifically Higgs (1995) says that clinical reasoning is:

“...the process of using thinking, interpersonal and clinical skills, and knowledge in order to acquire, evaluate and make sense of the mass of clinical information available to the health care practitioner during interaction with clients and thereby
make and implement, and evaluate, in association with the client, clinical decisions which are relevant to his or her situation and clinical problem.” (p. 13).

This definition of clinical reasoning still refers to clinical reasoning as a cognitive process, but also provides information about what additional factors impact the therapist’s thinking. For example, Higgs identifies clinical knowledge and experience, the contextual elements surrounding therapy, and the affect of interpersonal relationship between therapist and client. Similarly, the AOTA/AOTF commission study completed by Mattingly & Fleming broadened the discussion of how therapists structure the clinical reasoning process to an understanding that multiple forms of reasoning are integrated and occur simultaneously for occupational therapists. This leads to an understanding of clinical reasoning as a complex, and multi-faceted process (Kortman, 1995; Mattingly, 1991; Munroe, 1996; Schell & Cervo, 1993).

Types of Clinical Reasoning

The predominant types of clinical reasoning thought to direct a therapist’s thinking in clinical reasoning include narrative reasoning, procedural reasoning, interactive reasoning, conditional reasoning, and pragmatic reasoning.

Mattingly (1994) discussed narrative reasoning as a type of interpersonal clinical reasoning in which the practitioner and the patient collaborate to create an envisioned future for the client and work together towards that end. This type of reasoning has become a common topic of discussion in recent years as evidenced by the prevalence of literature on occupational storytelling, and story making (Clark, 1993; Crepeau, 1991; Mattingly, 1991).
Procedural reasoning is the process of defining the client’s physical or functional deficits. This definition is then used to determining what procedures or interventions may be effective in overcoming these limitations to function (Mattingly, & Fleming, 1994).

Interactive reasoning is the type of reasoning used by therapist’s to develop this understanding of what the injury or illness means to their clients (Neistadt, 1998). It has been proposed that, “Occupational therapists’ fundamental task is in treating what medical anthropologists call the illness experience” (Mattingly, 1991, p. 983). The illness experience is the subjective meaning each client constructs in relation to their particular injury or illness and how it will affect their lives.

Conditional reasoning is a complex form of social reasoning that encompasses the holistic considerations of a client’s situation (Mattingly & Fleming, 1994). These considerations include thinking about the client’s social contexts related to family, home, and community (Benamy, 1996). In this type of reasoning the therapist integrates these aspects of clinical reasoning to envision the client likely course following discharge to direct the therapy process.

Finally, pragmatic reasoning is a form of clinical reasoning that considers the practical issues that affects occupational therapy services (Leicht & Dickerson, 2001). These issues include the treatment environment, the therapist’s values, abilities and experiences, the financial constraints around the treatment process, and the clients potential discharge environment (Neistadt, 1998; Schell, 1998; Schell & Cervero, 1993).

These varied types of clinical reasoning described above are important in giving us language to discuss, and conceptualize the multiple aspects of clinical reasoning that
therapists simultaneously utilize in practice. However, it does not give adequate
information about what informs the thinking and decision making process, or how
therapists integrate these types of reasoning into practice.

Munroe (1996) states that in looking at the clinical reasoning in occupational
therapy, "a wide range of environmental, interpersonal, and intrapersonal
influences...impinge upon the decision-making process, motivate practice, and provide
justification for action (p. 107)." These influences include the contextual issues
surrounding therapy (Burke & Cassidy, 1991; Creighton, Dijkers, Bennett & Brown,
1994; Finlay, 2001; Mattingly & Fleming, 1994; Neuhaus, 1988), the dynamic
interpersonal relationship between the therapist and the client (Borrell, Gustavsson,
Sandman & Kielhofner, 1994; Gilfoyle, 1980; Peloquin, 1990; Rosa, & Hasselkus, 1996;
Schell & Cervero, 1993) and the intrapersonal influence of the therapist’s life knowledge
and assumptions (Chapparo & Ranka, 1995; Creighton et. al., 1994; Engquist, DeGraff,
Gliner & Oltenbruns, 1997; Findlay, 2001; Hooper, 1997; Kortman, 1995; Rodgers,
1983; Shell & Cervero, 1993; Tornebohm, 1991). To illustrate the apparent and subtle
ways that these factors influence therapists’ clinical reasoning, specific examples will be
given from research conducted in the field of occupational therapy.

Influences on Clinical Reasoning

Influence of Context on Clinical Reasoning

It has been concluded that the context in which a therapist practices not only
constrains the manner in which he or she goes about the therapy process, but in fact is an
inherent part of the reasoning process therapist utilize (Creighton, Dijkers, Bennett, &
Brown Howard, 1991; Strong, Gilbert, Cassidy, & Bennett, 1995). For example, as a
result of escalating health care cost it has become increasingly necessary to ensure the
cost–effectiveness of therapy services (Howard, 1991). The current environment of cost
containment and managed care may influence therapists to select intervention in light of
reimbursement restrictions (Burke, & Cassidy, 1991; Finlay, 2001). High cost technology
has been identified as an additional contextual factor that directs therapists reasoning.
Neuhaus (1988) suggested that technology necessitates the therapist to actively weigh the
cost against the benefit of a particular therapeutic intervention as a part of the
occupational therapy process.

Research has also established that therapists alter their clinical practice in order to
cope with increasing case loads by implementing procedure-centered treatments (Burke
& Cassidy, 1991; Mattingly & Fleming, 1994). In her study of twelve occupational
therapist in the United Kingdom, Finlay (2001) found that therapists were influenced in
their clinical reasoning by the productivity expectations of their employer and adopted
rote exercise during treatments in response to increasing caseload demands. In addition,
the length of treatment sessions is also a contextual influence on therapist’s clinical
reasoning. A study of a rehabilitation unit demonstrated that therapists consistently pace
treatments so that the end of the treatment hour coincided with the successful completion
of an activity (Creighton, Dijkers, Bennett, & Brown, 1994). In this situation the
institution scheduling policy influences the clinical reasoning that therapists utilized.

Culture has also been recognized as a contextual factor which influences clinical
found that therapist’s expectations were greatly influenced by the culture in which he or
she lived and practiced. For example, the American therapists studied believed that their
clients should have goals that were reflective of fundamental American values such as, "personal autonomy, victory over disease, diligence, and perseverance" (p. 636). These expectations influenced the goals therapists set for the desired outcome to measure success in therapy.

The specific setting where a therapist works can have a contextual influence on the clinical reasoning process. Spencer, Young, Rintala, & Bates (1994) proposed, “Thinking about health care institutions as local worlds with their own cultures” (p.55). For example, because occupational therapists often work within the institutional culture of a medical setting, it has been proposed that what they value and communicate is often primarily concerned with the technical aspects of care. However, it has been suggested that occupational therapist may continue to practice the more tacit and holistic portions of therapy but that they do not communicate this part of practice to other professions. Researchers in occupational therapy refer to this phenomenon as the underground practice (Fleming, 1991; Mattingly & Fleming, 1994).

Other affects of institutional culture include department traditions, power relationships between team members, documentation forms used, physician’s orders, and fear of litigation. These are all contextual factors that were considered by therapist’s when activities were selected and adjusted (Creighton, Dijkers, Bennett, & Brown, 1994; Howard 1991; Munroe, 1996; Neuhaus, 1988; Peloquin 1993).

Influence of Interpersonal Interaction on Clinical Reasoning

The interpersonal relationship between the therapist and client also influences the clinical reasoning process. In fact, a therapist’s effectiveness is often evaluated by the quality of the relationship between the therapist and the person being treated (Schell &
In order to assist the client in recovery, the occupational therapist must understand the meaning of a chronic illness or disability to that client. This requires collaboration between the client and therapist to individualize the treatment process (Mattingly, 1991). In this collaborative effort, the therapist must closely attend to the client to ensure that the therapy process is effectual. For example, a study by Creighton, Dijkers, Bennett, & Brown (1994) found that a therapist modifies the therapy process to provide an appropriate level of challenge by "attending to verbal and nonverbal cues from the patient to determine the effect of each modification" (p. 315). Borrell, Gustavsson, Sandman, and Kielhofner (1994) suggest both the therapist and patient hold their own set of assumptions, which can influence how they act in clinical situations. This is important because when conflicts between the goals of a client and a therapist exist "resolutions of the conflict can easily be tipped in favor of the therapist's view" (Rogers, 1983, p. 613). Rogers (1983) goes on to suggest that this is the case because the therapist is seen as the professional who has the knowledge and skills to alleviate the problems, which puts the client in a dependent and deferential relation. This dependency is compounded by the vulnerability the client may feel as the result of the injury or illness they are experiencing. This raises concerns about the personal assumptions that therapists are bringing to therapy process.

Influence of Intrapersonal Beliefs on Clinical Reasoning

Several studies in occupational therapy have suggested that a therapist's clinical reasoning is in fact influenced by personal factors. For instance, Creighton et al. (1994) describes intrapersonal influences in a study of clinical reasoning therapists used in working with patients who had suffered spinal cord injuries. This study found that
therapists relied on personal skills and values to make decisions about where to start and when to adjust therapeutic interventions.

A therapist’s personally constructed understanding of theoretical concepts provides another example of an intrapersonal influence on clinical reasoning. For example, Finlay (2001) performed a study to determine if holistic practice was a realistic possibility in occupational therapy given the current practice constraints facing occupational therapy. In performing this research she found that therapists, while claiming to enact holistic practice, had each constructed a very different meaning of what holism meant. Finlay (2001) explains this construction by saying that “the participants tended to merge different ideas, blending notions of humanism and person centered health-oriented practice into their personal versions of more general professional values.” (p. 272). As a result of these different interpretations, the manner he or she enacted or integrated holism into practice was unique. Understood in this sense the personal interpretations of professional values are a critical element in clinical action because it provides the parameters for action in regards to what a particular therapist views as acceptable in a given clinical circumstance.

In addition, two studies of the spirituality of practicing occupational therapists also suggest the intrapersonal nature of clinical reasoning (Engquist, DeGraff, Gliner & Oltjenbruns, 1997; Talyor, Mitchell, Kenan & Tacker, 2000). These studies reported that greater than 79 percent of the responding therapists agreed with the statement “their spirituality assists them in performing their daily job responsibilities.” These finding can be interpreted in at least two ways. The first interpretation would see the influence of spirituality on therapist’s clinical reasoning to be related to the cultural norms and values
that are a part and parcel of his or her particular religious tradition. A second potential understanding of the influence of a therapist’s spirituality would be to view spiritual beliefs as exerting a tacit influence over how the therapist views his or her clients, and how they perceive occupational therapy.

While in these examples the influence of internal personal beliefs is implicit, others have explicitly suggested that intrapersonal factors influence the therapy process. For example scholars have referred to the therapist’s underlying conceptions as beliefs, personal contexts (Schell & Cervo, 1993), personal paradigms, a life paradigm and a life world (Tornebohm, 1991), values (Fleming, 1991), perspectives (Rogers, 1983), and worldview (Hooper, 1997). Tornebohm (1991) said each therapist holds a unique view of humankind that is comprised of what is important to that individual including people, professional and other occupations, items in nature and culture, as well as their knowledge about nature, society, culture, and people. He and others suggest that therapists form a personal model or paradigm which is composed of theoretical elements, an understanding of the practical clinical situation and personal beliefs and values which influences therapist’s thinking concerning what can and should be done in the client-related circumstances. (Chapparo & Ranka, 1995; Kortman, 1995; Rodgers, 1983; Tornebohm, 1991). However, these scholars assume that the influence of this personal paradigm is a conscious part of the cognitive process of clinical reasoning.

Hooper (1997) as a result of her research suggests the pretheoretical commitments a therapist holds, which she calls worldview, could be traced forward into therapists’ practice. Although a therapist may not consciously be aware of these worldview beliefs, that they were tacitly affecting the way she or he envisioned and enacted the work of
occupational therapy. This influence affected an individual therapist's clinical reasoning by filtering and directing attention, guiding and constricting choices, and by affecting interpretations of the meaning of a clinical situation.

However, while others intrapersonal research has alluded to the importance of therapist's values, they have not adequately explicated the degree of influence that these factors hold. Lacking direct evidence of how personal beliefs may inform practice in occupational therapy it is beneficial to examine how other professions have conceptualized the inadequacy of theory to describe professionals thinking and actions in practice.

Interdisciplinary Reasoning

Nursing

Recent research in the field of nursing practice has examined nurses' perceptions of what constitutes good nursing practice (Smith, & Godfrey, 2002). In this qualitative study fifty-three nurses were asked two open ended questions in an attempt to discover what informs nurses' thinking in practical situations. The questions were as follows (1) a good nurse is one who...; and (2) how does a nurse go about doing the right thing? The responses placed emphasis on the personal attributes that nurses bring into nursing as a result of who they are. Thirty percent of the respondents attributed the nurse's character as the foundation and source of ethical decision-making and action. In contrast, only fifteen percent of the responses attributed doing the right thing in nursing practice to nurses professional knowledge base or those aspects of the nurse's practice that exist by virtue of his or her being a member of the nursing profession. This suggests that nurses' attributed knowing what the right thing to do in practice was because of personal
character characteristics, rather than professional knowledge or assumptions inherent to
the nursing profession.

**Education**

A similar body of research exists within education that studied the link between personal beliefs of teachers and the practice beliefs and actions implemented in professional practice. This research found that each classroom of students and each lesson taught represent such a unique context that the theoretical basis of knowledge within education is not sufficient to direct the teacher to a specific action (Kagan, 1992; Dirx & Spurgin, 1992). This research concluded that what constitutes a good teacher is a highly personal matter having to do with the teacher’s personal system of beliefs (Combs, 1982). To overcome this challenge of applying theory to practice, teachers rely largely on implicit sets of beliefs and preconceptions about their students and on values and norms about what one should do and how these activities are to be accomplished (Dirkx & Spurgin, 1992). The personally constructed cognitive pattern that results from these beliefs is referred to by authors in adult education by terms like personal constructs, conceptual maps, personal metaphors, personal epistemologies, personal pedagogy, belief orientations, knowledge structures (Roehler, Duffy, Herrmann, Conley, & Johnson, 1988), meaning schemes (Mezirow, 1991), and belief clusters (Green, 1971).

**Rehabilitation Counseling**

Related literature also exists within the profession of rehabilitation counseling. Several researchers in this field have found that counselors are drawn to, and use theories in their practice that confirm their own self-concept and philosophical beliefs about human nature (Corey & Corey 1998; Emener, 1997; Emener & Ferrandino, 1983).
Counselors apply theories that are an extension of their own values and personalities in practice (Nowlin & Blackburn, 1995). Some of the same literature also suggests that a counselor’s personal beliefs about human nature will influence his or her application of any theoretical principles in treating clients (Emener, 1997; Phemister, 2001; Nowlin & Blackburn, 1995). This is an important step in the consideration of the extent of influence that personal beliefs may have on professional practice. When seen in this light, worldview not only constrains reasoning by influencing the theory selected for use in practice but becomes an inherent part of the reasoning process. Phemister (2001) explains saying that clients are perceived through a “complex intellectual veil” as the application of any theory is personalized to be consistent with the counselor’s personal beliefs (p.5).

This review of interdisciplinary literature suggests that professionals often solve the ambiguous and uncertain nature of the problems facing professional practice by relying on personally held beliefs which have been referred to as character (Smith & Godfrey, 2002) and implicit sets of beliefs and preconception (Dirkx & Spurgin, 1992). Phemister (2001) called the effect of these personally held beliefs a “complex intellectual veil,” and suggested that the preexisting beliefs of a professional will impact how he or she views and interprets a clinical situation and in turn acts in practice (p. 5). This understanding of the reasoning process is consistent with Hooper’s (1997) suggestion that clinical reasoning in occupational therapy stems from the pretheoretical worldview beliefs that a therapist holds. With this understanding of how other professions account for the gap between theory and practice, it is this last concept of worldview which I wish to examine further related to clinical reasoning in occupational therapy.
Definition and Components of Worldview

A worldview is an interconnected system of beliefs that constitutes an individual's understanding about the world and the way it works, or should work (Stevenson & Haberman, 1998; Nash, 1992). A worldview is generally considered to consist of beliefs concerning human nature, what is true and how truth is known, the purpose and final outcome of history and human events, the meaning of good and evil, and what happens after death (Nash, 1992). Worldview beliefs have also been referred to by related terms including belief systems, perspectives, points of view, and personal ideologies (Dirkx, 1999). These beliefs are cohered to form a conceptual scheme or pattern of ideas which form the foundation for all other thinking (Nash, 1992). A conceptual scheme refers to the cognitive arrangements and relationships of the individually held worldview beliefs. This collection of worldview beliefs forms the presuppositions for subsequent thought and understanding of the world in which we live. The influence of a conceptual scheme should not be understood as theoretical in nature, but rather as pretheoretical as it is often not a conscious part of our thinking, but rather the unconscious foundation of thought (Walsh & Middleton, 1984). Perhaps this pre-conscious worldview provides the foundation for how therapists implement clinical reasoning in occupational therapy.

Proposed Relationship of Worldview and Clinical Reasoning

A number of occupational therapy authors have addressed the ethical aspect of clinical reasoning (Fondiller, Rosage & Neuhaus, 1990; Higgs & Jones, 1995; Rogers, 1983). In her Eleanor Clarke Slagel Lecture, Rogers (1983) stated that the ultimate question therapists must ask themselves is: “What, among the many things that could be done for this patient, ought to be done?” (p. 601). In order to make sense of a clinical
experience and answer this ethical question, a therapist must make an interpretation of the situation (Chapparo & Ranka, 1995). Schon (1987) identified this aspect of clinical reasoning for professionals when he said, “Through complementary acts of naming and framing, the practitioner selects things for attention and organizes them, guided by an appreciation of the situation that gives it coherence and sets a direction for action (p. 4).”

In forming this judgment therapists select the things that they hope or trust are cues to the meaning of the situation (Benamy, 1996). This framing of the problem determines what counts in the therapy process by choosing the things he will notice and address in treatment, and by extension what he or she will exclude from the therapy process.

Dewey (1933) in discussing how professionals make decisions suggests that there are no hard and fast rules for this process by which they select and reject, or focus upon the significant cues in making this judgment. In part the framing process is guided by the practice model a therapist uses in treatment (Benamy, 1996). However, in clinical reasoning rarely if ever does a therapist adhere to a theoretical practice model in its entirety. Instead, they pull in pieces of several different models and construct their personal models relevant to a particular client and their circumstance (Kortman, 1995).

This is crucial to understanding how therapists conduct clinical reasoning. It has been proposed that expert occupational therapists rely on an intuitive knowledge and simply “know” what to do in framing the clinical reasoning process (Benamy, 1996; Mattingly, 1991). This intuitive judgment has been shown to be a necessary and legitimate part of expert decision-making because of the complexity and uncertainty inherent in professional reasoning (Dreyfus & Dreyfus, 1986; Schon, 1983). However, by relying on intuition to frame a clinical situation therapist’s assumptions enter the
clinical reasoning process. Heidegger (1962) stressed, “an interpretation is never a presuppositionless apprehending of something presented to us” (p. 191). Instead, a person’s cultural-social background is always implicitly present and gives him or her a pre-understanding from which to understand the world. These preconscious expectations form the perspective upon which we base our understandings of any situations (Kagan, 1992; Kuhn, 1970; Mezirow, 1990; Mezirow, 1991). Brookfield (1987) explains that preconscious assumptions that an individual holds result in blind spots in his perception of reality at every major level of behavior. Mezirow (1990) states, “what we do and do not perceive, comprehend, and remember is profoundly influenced by our meaning schemes and perspectives” (p.1). As a result the assumptions that one holds are, “pivotal elements in the perceptual filters that mediate our interpretations of reality” (p. 47).

What therapists perceive and fail to perceive and what they think and fail to think in the interpretive process is powerfully influenced by the set of assumptions that structure the way they interpret clinical experiences (Chapparo & Ranka, 1995). Worldview beliefs then may provide the basis for how a therapist frames the clinical situation and therefore influence the occupational therapy process from its inception by mediating our interpretations of clinical situations, by which we determine what has value in the therapeutic process.

Implications for this Study

Clinical reasoning in occupational therapy as in other professions has come to be understood as a complex multifaceted process in which therapist simultaneously reasons in a several ways. Munroe (1996) states that the clinical reasoning process in occupational therapy involves “a wide range of environmental, interpersonal, and
intrapersonal influences" that "impinge upon the decision-making process, motivate practice, and provide justification for action (p. 107)." Because of the complexity of this process and the number of factors involved, application of existing theories to practice is an inadequate explanation of clinical reasoning conducted by occupational therapists.

Contemporary notions of clinical reasoning describe a highly individualized thought process (Chapparo & Ranka, 1995; Hooper, 1997; Kortman, 1995; Munroe, 1996). Therapists in the clinical reasoning process in order to make sense of a clinical situation must make an interpretation of it. The first step for a therapist to proceed is choosing among equally valid alternatives (Benamy, 1996; Hagedorn, 1995; Mattingly, 1991). This process of naming and framing directs the subsequent understanding, thinking, and actions of therapist's clinical reasoning.

Some scholars in occupational therapy have identified intrapersonal factors influencing clinical reasoning as the therapist’s underlying beliefs, values (Fleming, 1991), perspectives (Rogers, 1983), as well as his or her personal context (Schell & Cervero, 1993), internal frame of reference (Chapparo & Ranka, 1995), life paradigm, (Tornebohm, 1991), and worldview (Hooper, 1997). Literature in occupational therapy has proposed that a therapist's viewpoint or perspective translates into different kinds of practice in which a therapist is influenced in the selection of treatments by their personal assumptions and experiences (Hooper, 1997; Kortman, 1995; Schell, & Cervo, 1993; Tornebohm, 1991).

In forming this interpretation of a situation a therapist's pre-theoretical assumptions or worldview may influences both what the therapist's will select and attend to and what factors will be excluded from attention. As such, the manner in which the therapist
constructs their personal model may be a highly personal process in which the therapist’s values and beliefs act as a filter, which influences his or her clinical reasoning and determines the subsequent course of action. Moreover, very few studies have explored how therapists view the connection between their personal beliefs and clinical reasoning. Therefore the purpose of this study is to examine this aspect of clinical reasoning, specifically related to how a therapist’s experiences the effect of their worldview influencing their clinical reasoning and action.
CHAPTER 3

METHODOLOGY

Study Design

The intent of this study is to understand how therapists' experience the relationship between their worldview and their clinical reasoning in practice. The manner in which researchers study a phenomenon should be related to the specific characteristics of the subject of their inquiry (Hollis, 1996). Contemporary understanding of the process of clinical reasoning identifies it to be an internal and highly personal process in which therapists construct meaning (Hooper, 1997; Kortman, 1995; Munroe, 1996; Tornebohm, 1990). Because the nature of this constructed relationship is complex and highly individualized, it is necessary that the research design allows the researcher to enter into a relationship with the occupational therapist involved in the study. Studying this phenomenon by utilizing a qualitative research paradigm will enable such a relationship.

One type of qualitative research particularly well suited to creating this complex picture is the phenomenological study (Creswell, 1998). The phenomenological method is distinct from other qualitative designs in that it, “attempts to go beyond immediately experienced meanings in order to articulate the pre-reflective level of lived meanings, to make the invisible visible” (Kvale, 1996, p. 53). By describing the meaning of the lived experience of several individuals about a concept or the phenomenon being studied, the phenomenological studies attempts to determine how people make sense of their lives and experiences, and discover their cognitive structure of the world (Creswell, 1998).
This study utilized a phenomenological research design to understand the worldview beliefs that a therapist holds and how they experience the relationship between these worldview beliefs and practice. The phenomenological study examines human experiences through detailed descriptions of the persons being studied (Creswell, 1998). This was accomplished by studying a small number of subjects through extensive engagement to develop patterns and themes of meaning related to the phenomena (Creswell, 1998). In the phenomenological method, the researcher collects data from persons who have experienced the phenomenon being studied. This is often accomplished by using a conversational interviewing technique known as the semi-structured interview (Creswell, 1998).

**Role of The Researcher**

In phenomenological research the researcher is the primary instrument in data collection (Creswell, 1998). While an understanding of presuppositions as they relate to a therapist’s worldview and the effect on clinical reasoning is the premise that is being studied in this research, presuppositions also have the potential to affect the reporting of the finding of this study. This is especially true in phenomenological research. Because the researcher directly interacts with the participant this relationship has the potential to influence the data collected (Lincoln & Guba, 1985). Therefore, in conducting this type of qualitative research Lincoln and Guba (1985) suggest that the researcher accepts and explains his bias, rather than attempting to eliminate its effect. This step also allows the reader to compare the results of the study to the expectations of the researcher upon undertaking this study. The reader then is able to determine if the interviewer influenced
the contents of the subjects’ description so that it does not truly reflect the subjects’ actual experience (Polkinghorne, 1989).

In order to explicate my bias I will explain the manner in which I developed my initial interest in studying this aspect of clinical reasoning. I am a third year student in an entry-level masters’ degree program in occupational therapy. Through observation of other therapists and the unique manner in which they construct and practice occupational therapy and my own personal experience, I have come to believe that a therapist’s clinical reasoning is in part informed by their worldview beliefs. I believe that this influence is not only related to the interventions that a therapist uses in treatment, but rather that it is intertwined throughout the entire clinical reasoning process. Although my beliefs were not clearly conceptualized upon undertaking this research, it was my personal experiences that generated my interest in conducting this study. By conducting this research I hope to provide a more comprehensive insight into how occupational therapists’ worldview beliefs influence the way they envision and enact the work of occupational therapy.

Bounding the Study & Data Collection

Participants

In a qualitative methodology the inquiry focuses in depth on a relatively small sample which is often purposefully selected (Creswell, 1998; Lincoln & Guba, 1985). This purposeful sampling allows for selection of participants who will be able to provide information rich data related to the phenomena being studied. Participants for this research were selected using a combination of methods which include convenience sampling, homogeneous sampling, and criterion sampling strategies.
Criterion sampling is used in phenomenological research to ensure that the participants have experienced the phenomena and are able and willing to articulate their experience (Creswell, 1998). McKay & Ryan (1995) in studying occupational therapists found expert practitioners were able to devise a more complete picture of the client, and to more accurately and efficiently assess their needs. It has also been suggested that expert therapists have a greater understanding and awareness of their own values and the worth of others (Strong, Gilbert, Cassidy & Bennett, 1995). This greater insight will lend itself an improved ability of these therapists to verbally explicate relevant data concerning the phenomena being studied. Expert clinicians are characterized in occupational therapy literature by experience, creative reasoning, commitment, knowledge, confidence, and vision (Burke & Depoy, 1991).

An additional consideration regarding participants included the setting in which he or she practices. Literature has established that the clinical reasoning of therapists is often influenced by the culture of the practice environment (Creighton, et. al, 1994; Howard, 1991; Munroe, 1996; Neuhaus, 1988, Peloquin, 1993; Spencer, et. al, 1994). In order to control the impact of the practice environment, a homogeneous sample of therapists from the same facility who have practiced in that environment for a minimum of three years will be used.

The nature of interviews used in phenomenological research presents an additional challenge. Because of the in-depth nature of extensive and multiple interviews with participants utilized in a phenomenological study it has been recommended that a convenience sample be used to select participants that are easily accessible (Creswell, 1998). To overcome this challenge I selected a local setting in which I currently work to
provide this easy access. Although I have professional relationships with the subjects in this study, I do not currently work directly with any of the participants.

Following approval by human subject review board (HSRB) at Grand Valley State University, these purposive sampling techniques were used for selecting the participants. This study utilized three practitioners who were identified through both personal experiences of the researcher and key informants. Key informants included a supervisor at the setting, former and present co-workers of the participants, members of this research committee, and other occupational therapy professionals.

**Ethical Considerations**

In phenomenological research the interviews used to collect data may reveal sensitive information of a personal nature. In this study, participants may discuss religious beliefs, views or human nature, beliefs concerning life after death, and life experiences of both a professional and personal nature. As a result the following precautions suggested by Creswell (1998) were utilized to safeguard the participants. First, a coding system was used on all audiotapes and field notes to protect the identity of the participants. These audiotapes were immediately destroyed following transcription. Second, the objectives of the research and the manner in which the data would be used were clearly stated verbally and in writing to the participants. All participants were made aware of their right to withdraw from the research at any time without explanation. Written permission was received in a consent form prior to interviewing or data collection to ensure that the participants had been appropriately informed. Verbatim transcriptions and written interpretations and reports are also made available to the
participants. In addition this study was approved by the Human Subject Review Board at Grand Valley State University prior to any data collection.

Data Collection Strategies

For a phenomenological study Creswell (1998), identified in-depth interviews as the primary data collection method. Three therapists were initially contacted by phone to secure interest and to explain the purpose of the study. Each of the three participants initially contacted agreed to participate in this study. Interviews were scheduled at a time and location convenient to the participant. The consent form (Appendix A) was given at the time of the interview to provide the participants with information regarding the study. In the event that a participating individual decided to withdraw from the research, the study would proceed with the remaining participants. Two in-depth semi-structured interviews were conducted with each participant. The questions for the initial interview were adapted from a study by Richardson (1991) which examined the relationship between classroom teacher and his or her personal beliefs, and from a study of therapists assumptions (Pace, Vernon, & Yenny, 2002). Appendix B details the initial questions that guided the interviews. Additional probing questions were added to clarify or further explore data related to the studied phenomena, which emerge through the interviewing process. The interviews lasted from 60-90 minutes and were conducted at times and locations of convenience to the participants. The interviews were audiotaped in their entirety and verbatim transcriptions were made of each audiotaped interview. Field notes were also taken during the interviews in order to guard against potential equipment failure and as a means of preliminary coding.
Data Analysis

The analysis of qualitative data in phenomenological research is not a one time event, but rather an ongoing progression or process (Erlandson, Harris, Skipper, & Allen, 1993). This ongoing process is generally considered to consist of the following two stages as described by Creswell (1998).

The first stage of the interactive process of data analysis begins during data collection at the research site during data collection. Here the researcher forms a tentative hypothesis of the phenomena being studied through a review of literature and forms initial interview questions as a result of these findings. The researcher then begins collecting data with the first participant. New data that is obtained through this interaction tests and reshapes the tentatively held hypothesis. The data collector as a human instrument responds to the first available data and forms a very tentative working hypothesis that causes modifications to subsequent interview questions.

The second stage of data analysis occurred after all of the interviews have been completed. In this stage the audiotapes were transcribed and the transcriptions and field notes were read to gain an overall sense of the data. This general review of information included jotting down notes and initial impression in the margins of texts as an initial sorting-out process to develop a short list of tentative codes (Creswell, 1998). At this point the data was analyzed and coded for emerging themes identified through initial review. After preliminary analysis codes were formed for each therapist’s perception about the nature of humans, the nature of work, the transaction between worldview and work, an apparent discomfort with this relationship, the nature of knowledge, personal images of who each therapist desired to be, and what constituted “real” occupational
therapy. Through use of these codes the researcher pulled out significant statements from each description. These statements were then formulated into meanings, and these meaning were clustered into themes. This analytical process was repeated approximately three times for each interview over a period of two weeks to ensure that the themes accurately reflected the data and to enhance dependability. During that period, the thesis committee chair was also contacted regularly for advice regarding analysis techniques and thematic formation. When the analysis was completed the researcher integrated these themes into a narrative form that create an understanding of the phenomena studied.

Final themes were conceptualized under the relationship between personal and professional identity in occupational therapy. This included the initial attraction to occupational therapy, the way each therapist connected with others, how he or she envisioned the role of occupational therapy, and the personal meaning and satisfaction that resulted from working as an occupational therapist. This interactive refining process continued throughout data collection, data analysis, and writing until the final report was written resulting in a descriptive narrative that a synthesis of the knowledge about the effects of worldview on a therapist’s clinical reasoning and action (Erlandon, et. al. 1993).

**Trustworthiness**

Trustworthiness in this study was ensured through two primary means. First, involving multiple persons in the interpretative process has been identified as a way to confirm if interpretive patterns fit together logically and to explore other potential arrangements of data (Creswell, 1998). Committee checking occurred frequently with the committee chair during the analysis of the data. Secondly, the methodology of this
research provided an adequate interview time of two sixty to seventy-five minutes periods. This prolonged engagement has been identified as a key to understanding the meaning of the phenomenon to the individual (Creswell, 1998). In addition, active listening and verbatim transcriptions of all interviews was employed as a means of member checking during the interviews and during data collection to confirm what was heard (Creswell, 1998).
CHAPTER 4
RESULTS/DATA ANALYSIS

Overview

The purpose of this study was to examine how occupational therapists perceive
the relationship between their foundational philosophical beliefs or worldview and the
clinical reasoning and actions they utilize in practice. Throughout these interviews each
participant described a significant intertwining between his or her worldview and clinical
reasoning as an occupational therapist. This intertwining was evident in stories and
examples each gave and implicit in how they described their clinical practice. In order to
illustrate the relationship between their worldview beliefs, clinical reasoning, and practice
the results of this study will be presented in a narrative format. In these narratives, the
prevalent themes related to the therapists’ perception of the influence of their worldview
on practice will be presented. In addition to biographical data related to years of practice
and setting of practice, and educational background these narratives include the initial
attraction to occupational therapy, beliefs about the human, and beliefs about the role of
an occupational therapist. The effects of worldview on clinical reasoning also have an
effect on the way they connect with others, the interventions they use in treatment, and
what they consider successful in occupational therapy practice. Personal meaning and
satisfaction that each individual gets from his or her work as an occupational therapist
also becomes apparent through these narratives as each participant experienced a
blending of personal and professional identities and values. Each participant has been
given a pseudonym to allow for referral during the subsequent discussion of results.
Participant History and Narratives

Jane

Jane has been practicing in the field of occupational therapy for 19 years. Since becoming a Registered Occupational Therapist (OTR) she has primarily worked in an inpatient rehabilitation hospital with patients who have suffered brain injuries and strokes. She has also performed coverage in acute care and outpatient settings. When asked why she pursued a career in occupational therapy Jane explained that she was from a large family where many of her other family members were in business, but knowing that she was not interested in that type of work. She also reported “knowing that it was in her character to work with and be around people” and “listening to that in myself.” Jane started working in a hospital setting when he was sixteen and discovered that helping others was enjoyable and felt like it had value. She also discovered that she felt better about herself when helping others. In addition Jane reported being shy and “knowing that by working with people would help her to overcome some of that shyness.” In her early years of practice in an inpatient rehabilitation setting Jane described, “not knowing who she was as a therapist.” So she was constantly “looking to others” for feedback to help point her in different directions. At that point in her career occupational therapy was about learning and applying specific techniques to help a person recover from an illness or injury. Jane also reported experiencing a feeling of discontent with practicing in this setting, so she moved to working in a newly developed low level brain injury (BI) program.
As a result of working in this setting, Jane reported development of self-confidence in her view of herself as a therapist. She explained it as no longer “being intimidated by other therapists” and “starting to know who she was as a therapist.”

Through her experiences in the BI setting, Jane expressed a shifting view of her patients and of her role as an occupational therapist. Because of the low levels at which these patients were functioning, the increments of change from therapy were very small and only visible by stepping back and looking at the total picture. Jane no longer viewed her work as “doing a technique appropriately” instead she saw it as “really honing in on caring for her patients.” She saw a large part of her role as an occupational therapist to be “helping people to deal with tragedy. That their lives had been interrupted and they needed help working through it.”

Jane expressed a view of all humans as being inherently good even though that good does not always come out. She also stated that humans have a desire to “love and be loved”, to “want to learn”, to “strive to be a better person”, and to “care beyond yourself.” She attributes these beliefs to her religious and cultural beliefs, a sense of community, and family influences. At the same time Jane feels it is important that she not judge her patients, even if their values are in conflict with hers, because it is her job to “help heal them.”

Jane facilitates this healing process by allowing her patients the “environment that provides the opportunity for them to heal as best as they can.” She claims that her personal and professional beliefs “are so intermixed you can’t separate them and described her approach to working with patients as being “who she is as a person”, and she approaches life outside of work in the same way. For example Jane talked about
being a problem solver, liking “to be in control”, and “having a logical progression” in life and in her approach to interacting with clients and providing care. She explained that in practice she feels comfortable using more traditional techniques because “it’s a little more scientific, and it logically makes sense to me.” She uses “a lot of the basic techniques taught in school” as well as “some techniques learned through continuing education” to facilitate this environment. The techniques she uses in practice include a lot of Neuro-Developmental Techniques (NDT), handling techniques such as Bobath principles, and other motor control theories. Some of the techniques learned through continuing education include brain gym exercises, cranial sacral techniques and myofacial techniques. Jane feels that many of the alternative techniques that some therapists are implementing in their practice are similar to traditional occupational therapy interventions, but are framed in a slightly different manner. It is her understanding that techniques such as acupressure and myo-facial interventions are giving the same input that she does by using NDT.

Jane talked about experiences with co-workers and continuing education as having an influence on her beliefs. She attributed these changes to both professional experiences and personal maturation and experience saying, “as you gain confidence and aren’t so worried about what others think, that’s when learning can take place. I’m not threatened like I was by change. I don’t feel anymore like questioning what I do is showing weakness as a therapist.”

Jane also referred to an instinctual or intuitive component to her practice. She described this as having a “strong gut level” feeling in her interactions with clients, their families and even students and that she has an increasing confidence in the accuracy of
these instincts. These instincts enable her to “walk in and really have a pretty good idea” of the recovery a patient will make. Life experiences and professional experiences, as well as verbal and nonverbal cues such as patient’s mannerisms inform this “gut level” feeling for Jane. Jane identifies positive outcomes to therapy as “functional gains, the ease of accomplishing tasks, as well as the self-esteem and confidence level of patients in their abilities.” Jane continues to feel a sense of satisfaction because of her job and the opportunity that it gives her to “care beyond herself.” She also feels that her work and the way she interacts with others allow her to serve as a role model to other family members.

John

The second therapist included in this study is John, a male occupational therapist who worked in the field of occupational therapy for 12 years. The first three years were in a long-term care facility. However, for the past nine years he has worked as a part of a stroke program at an inpatient rehabilitation hospital. When asked to describe his initial attraction to occupational therapy, John expressed an interest in a kind of service profession related to teaching and helping others, and he began to seek a career in line with these aims. Initially he thought that his aims might be met through teaching at the college level. However, through interacting with patients and therapists while volunteering and working as an assistant in a hospital setting, he saw “the individual opportunities that they (therapists) had to really help people one to one on a daily basis.” He decided that a career in therapy was “a great way to be involved in helping people and doing it from a level where there is a technical aspect that maybe they (patients) don’t understand.”
Through volunteer experience and subsequent work as a residential staff member in a brain injury program, John determined that he was interested in occupational therapy in particular. For John the way OT's interacted with people was what drew him to the profession. He talked about a “personal connection with the occupational therapists” that he did not feel with other therapy professionals. John “noticed a difference personality wise. For physical therapy it was more about what the therapist wanted the patient to achieve.” In occupational therapists he observed, “it was the occupational therapists that would really click with people. They were interested in the person and really wanted to know about them. They also were fun and interacted with each other and with other staff.” He expressed a desire to want to be a part of that kind of a profession. He also felt that working with patients in a functional and holistic approach was a more effective approach then what he observed other professionals doing. He talked about an early experience observing a really great therapist who “really solidified for me that these were people [occupational therapists] that really tried to work with people from a holistic perspective. To me that was very important anytime I was going to be interacting with another human being.” He observed that therapist using weaving to teach a visually impaired patient adaptive strategies to compensate for his loss of vision. What struck John about this experience was how the therapist enabled the patient by “using his strengths to allow him to continue to be the person he had always been.”

For John, the relationship between work and who he is as a persona is “symbiosis.” “Everything I do reflects on my work, and I think that everything that happens to me at work reflects on who I am as a person.” For John behaviors which characterize his personal character and have become a part of his work include being
naturally curious about what motivates people and always attempting to understand the complexities and dynamics of any situation. He says that “OT is who I am, and what I do, it makes all the sense to me.”

John feels that the unique contribution that occupational therapists possess is the ability to immerse themselves with the patients in treatment and connect with “the true essence of the human being.” John said, “we are different we bring something unique.” This uniqueness is more than just a focus on function because other professions focus on that to a lesser degree. “The bigger area that I think is more important in occupational therapy is the meaning” in a person’s life. For John meaning is about “celebrating life, to have fun, and enjoy it.”

John also talked about how his own biases can influence the therapy process. He said that, “you have to be careful and realize that you have your own biases.” He attempts to control this by “being open and removing my own biases in what people find as meaningful and important to them.” “People who are truly gifted as therapists have good interaction skills and really immerse themselves in the treatment. They get involved with the patients.” This immersion allows therapists to “find out what the true essence of the human is and connect with it and to find out what that person is feeling.” He feels this essence can be revealed through verbal interactions or by the person “trusting me and allowing me to be with them.” John in talking about a specific patient says just by watching him perform an ADL, “I figured out something about him and his personality. I immersed into therapy with him. That’s what OT is about.”

John sees his role as an OTR as “providing an opportunity for them [the patients] to find ways that they can either heal themselves or ways to compensate or accommodate
to their change.” In working with patients John attempts to create an environment which “allows patient’s to find a path or way through their dysfunction toward function.” He states, “We don’t fix people. Doctors and mechanics fix things.” John believes that a human has innate drives to be normal and balanced, to have power over their environment, and to find purpose in life by what they are doing.” By using these drives he feels that occupational therapists are able to provide opportunities to enable clients to find meaning in their lives again following an illness or injury. John explained that the physical aspects of the activity are really deferential to the meaning that the activity holds for the individual. Using functional activities in treatment allows the patients to reconnect with the “human quality they possessed and to get back to finding a purpose in life” in a way that other treatments cannot. Because of this belief, John attempts to implement manual techniques or adjunct activity only as a precursor to functional activities. To illustrate this, John related a story about a patient he was working with that he felt had really caught the essence of occupational therapy. The patient was explaining the difference between the disciplines in rehabilitation to a family member. The patient said, “Physical therapy is teaching me how to walk again, speech therapy is teaching me how to talk again, and occupational therapy is teaching me how to live again.”

For John providing direct patient care is the part of the job that is personally satisfying because he is getting a lot from his relationships with his patients. John stated “I take a lot of pride in what I do. I really care what OT is about.” “Through my work I also want to build positive experiences that are positive in my life as well.” John identified coming to work everyday as a part of his religion, that it’s a part of his involvement in humanity. Through his work he is able to celebrate who his patients are
as humans. By helping people at work to have positive experiences, John feels that he is able to build experiences that are positive in his life as well. John stated, "There is enjoyment in working with someone when you know they look at you, trust you, enjoy working with you, and look forward to treatment time with you. John also speaks of using his work as an opportunity for personal growth. He uses his interactions with patients to "continue to grow" and to "continue to learn new things." "As I get older I find that that is important to me in my life." He admits that while this may not sound altruistic he believes that we do and should "take a lot of good things from what we do" and occupational therapy provides that opportunity for him. For John a part of that good is being able to instill values in his children, by showing them what is important in life.

Sally

Like Jane and John, Sally works in an inpatient rehabilitation setting. She has been practicing in the field of occupational therapy for 20 years. The initial six years of practice in the field were as a COTA. However she returned to school and for the last fourteen years has worked as a staff therapist in the same setting. In this setting she works primarily with patients who have suffered strokes, but also works with pediatric patients. In describing her attraction to occupational therapy Sally talked about knowing at an early age that she wanted to be a caregiver. By watching a therapist help her mother, she saw a helping profession like therapy as a way to be able to influence lives in a supportive and caring way and reports starting school knowing that she wanted to work in some kind of medical career.
Sally, because her mother was ill, wanted to attend college close to home. She began a nursing curriculum at a local school, but through volunteering at an acute care hospital, Sally had an opportunity to observe first hand what working in the field of nursing entailed. She did not feel like this was a good fit with who she was as an individual. So Sally began exploring other health care professions. By reading about occupational therapy in the program description of a college catalog, Sally decided that she wanted to become an occupational therapist. She was not sure what it was about occupational therapy that attracted her, but “feeling a connection” she “listening to that feeling.” In looking back Sally thinks that the attraction to occupational therapy was “the framework of using everyday activities to heighten people’s recovery.” Sally explained that she strongly believes that “everything happens for a reason” and that opportunities come up that we are supposed to take advantage of.” As a result when she inquired about a certified occupational therapy assistant program (COTA) at a community college and found out that there was no waiting list to enroll, she “knew” that this was what she was suppose to do. She enrolled in this program and eventually in a bachelors level occupational therapy program.

Believing that everything happens for a reason also helps to explain how Sally continues to develop her beliefs and practice as an occupational therapist. Sally talked about several personal experiences that have influenced her beliefs about who she wanted to be as an occupational therapist. The first experience was with observing a physical therapist that was treating her mother. As she watched this therapist, she expressed a desire to, “want to be able to influence lives in that way and to be supportive and caring.” Sally continues to want to “heal” others through her interactions. Sally also talked about
an experience while working in the radiology department of a hospital where she pickup up a myo-therapy book on trigger point therapy that she called “a cookbook thing.” By reading through this book she reported trying the techniques with people coming in for x-rays and having positive results. She states, “I knew then that manual therapy was going to be part of what I would continue to do.”

A second example is evident in the courses that she took in the course of schooling to transition from being an COTA to a registered occupational therapist. Sally took several extension classes and weekend courses to prevent having to travel to the main campus. She reported that many of these classes were a part of a holistic health program. The philosophy in these courses influenced Sally’s belief that an illness is a physical manifestation of an internal dysfunction. She believes that the true source of the problem is a failure to “listening to their inner guidance.” Sally believes that clients have the answers inside, and that her role as an OT is to enable her clients to see those answers.

Sally explains that she views humans as multidimensional beings with spiritual, physical, etheric, mental and emotional aspects. Because of these multiple dimensions all humans while unique, have the same nature. Through these experiences and with the influence of personal circumstances, she reports personally evaluating the religious beliefs that were a part of her upbringing. She reports that she now “listens to that inner god’ and has formed a thinking system with beliefs “outside of formal religious structures that exist in our society.”

A third example Sally gave of her belief that everything happens for a reason became evident as Sally talked about the continuing education courses she attends. She said that she will take a continuing education course and “when I come back those
patients on my caseload will need that specific treatment done. Its really kind of how it goes, they come in the door with the need of exactly what I have just learned.” She feels that the reason she felt a need to take a particular course is because the clients she will have in the future will need the information she learns in that course.

This understanding of the nature human nature is very evident in how she approaches work as a therapist. In treatment, she explains “the theory is still there. I can’t just separate the human body as just a physical body. I have to incorporate the entire person and all they are.” Sally explains that listening to the inner god remains a crucial part of her practice with patients, and she believes that how she interacts with others reflects who she is and what she believes. She feels that human nature allowing us “to sit together and kind of gel and to know things about each other.” She states because of our human nature the interaction in therapy allows for two equal persons to be comfortable in interacting which allows “both of us [therapist and client] to be happy and feel loved… and have this exchange of peace.” As a result she often approaches a treatment session by keeping the clients goals in mind without having a specific intervention planned. Instead she “actively listens to what the [client’s] body needs” during a treatment session. She explains this active listening as “being very present while I’m working.” Sally believes that she has the gift of being able to “see” and that this is a gift that she uses regularly and continues to develop. She says that she will “try something and see if it feels right then trust that inner feeling” in herself.

Through her personal experiences Sally believes that positive outcomes for patients are often best accomplished by using treatments outside of traditional occupational therapy interventions. She understands her role as an occupational therapist
as helping patients connect with and listen to that inner voice. Some of these untraditional interventions include Moshe Feildencrest exercises, cranial-sacral techniques, acupressure, energy work and parts of the philosophy of esoteric healing. She explained that “I will see if it feels right. If it feels right and things fall into place like everything else in my life has, I trust that.” Although she does not formally implement other techniques in her practice at this hospital, that things like esoteric healing, “are still in my philosophy. I can’t get rid of it, it’s a part of who I am.” For example, because of her belief that a illness is primarily a physical manifestation of an internal problem, her focus in treatment is related to that internal essence and she will only implement adaptive equipment as a last resort.

The strength of these beliefs and the importance of being able to include the assumptions of these beliefs in her practice was evident when she said “if the only things I could use were the things I had learned when I was in school...then I would say I will leave the field and find something else to do.” However she feels that regardless of where her work takes her that she “will always be an OT because what I consider OT’s realm is making people feel good.” Sally referred to her identity as being “a born OT.” She says that she is “raising her kids as an OT” because she maintains this philosophy in all of her roles. Sally explained that her work allowed her to be “successful, happy and to feel good about herself and at peace.” Sally sees her work as an opportunity to help others in this process as well as to further her own development. She states, “I think that is why I still like what I do today after twenty years of practice.”
Themes in the Relationship Between Worldviews and Practice

There were several common themes that connected each of these therapists in his or her experience of the relationship between worldview and practice. First, each therapist discussed an initial interest in a helping profession because it was consistent with what was valuable to him or her and fit the skills that he or she possessed. Subsequent exposure to occupational therapy resulted in an interest in occupational therapy specifically, as opposed to other health care professions for the participants.

Beyond the initial interest in a helping profession, the participants in this study perceived occupational therapy as a career, which supported personal beliefs and would allow for the expression of those values. The initial attraction to occupational therapy because of its consistency with each individual’s worldview beliefs was developed further and refined through the personal and professional experiences of the participants.

Personal growth and fulfillment through work was also described and valued by each participant. Each saw his or her work as a means of finding meaning and satisfaction in life. A part of this meaning became evident as participants discussed the relationship between his or her role as a professional and how it carried over and affected the manner in which he or she raised children and demonstrated values to other family members.

There is also evidence of personalized worldview beliefs in how each therapist enacts her or his work as an extension of who he or she is. Therapists’ perception of this interconnection was evident in several areas. Their beliefs translated into practice in regards to how he or she conceptualized the role of an occupational therapist, connected with patients, and selected interventions. The therapists in this study perceived their
work as an occupational therapist as providing a critical element in a client's treatment because of the connection that he or she was able to form with a client. The participants felt that this connection provided a unique and important insight into each client as a unique person. John, Sally, and Jane all talked about this relationship providing patients an opportunity to find meaning in their life again. However, there were differences in how each individual envisioned this relationship.

A merging of personal and professional identities was also often apparent in these narratives. On one hand, the participants valued and utilized uniquely constructed interpretations of occupational therapy theory in practice that was related to his or her personal values. At the same time there was also a discomfort with the thought that his or her profession practice would be affected by personal beliefs and values. So, although the interrelationship of personal and professional identities was valued, the therapists in this study emphasized an attempt to not let these values bias the treatment process.
CHAPTER 5
DISCUSSION AND IMPLICATIONS

Review

As stated in Chapter 1, the purpose of this study was to determine (a) from the therapists’ point of view, how does their worldview influence their professional practice, (b) how do therapists perceive and describe the link between their worldview and clinical practice. The results of this study suggest that an individual’s worldview beliefs impacts clinical reasoning and clinical practice. Throughout the interviews several recurring themes were identified. The positive relationship between each therapist’s worldview and how he or she directs the clinical process became the overarching theme in this study.

In this chapter the first section, Relationship Between Worldview and Practice, addresses the nature of the relationship between therapists’ worldview beliefs and how they perceive and enact their work in occupational therapy. Worldview is related to practice in that is seemed to guide therapists’ initial attraction to occupational therapy, how they expressed personal identity through occupational therapy, and how they connected with others through occupational therapy. The therapists’ worldview provided a context in which their personal and professional identities merged.

In the second section of this chapter I will discuss the issue of professionalism in occupational therapy as it relates to the personalized way that therapists construct the clinical reasoning process and how it affects occupational therapy’s professional identity. The final section of this chapter will discuss the importance of therapists examining their worldview for how it impacts practice.
Relationship Between Worldview and Practice

Initial Attraction

“One of the most compelling needs that every human being has is to be able to express his or her unique identity in a manner that gives meaning to life” (Christianson, 1999). McAdams (1997) proposed that people make sense of their lives and create meaning through creating a coherent life story. He suggests that we create these life stories around a particular vision or image. Responding to and building a life around an image of who we might become may explain the initial attraction that each therapist felt towards occupational therapy.

The participants in this study were attracted to occupational therapy because of its potential to live out a particular self-image that seemed to be realized through his or her professional practice. For example Sally knew at an early age she was going to be a caregiver. By watching a therapist treat her mom she decided “I want to be like that. I want to influence lives and be supportive and caring.” John, while still an undergraduate in school, knew he wanted to pursue some kind of service profession, which would allow him to help people. His initial interest was in teaching but, by watching occupational therapists work he decided “this would be a great way to be involved in helping people and doing it from a level where there is a technical aspect that maybe they don’t understand that I can help them with.” John believed that unlike teaching in a classroom of students, occupational therapy would allow him to form close personal relationships with people by working with them in a holistic manner. It was this image that drew him to occupational therapy.
Worldview In Identity

In addition to the initial attraction to occupational therapy, each participant in this study constructed practice in such a way that allowed for the personal expression of his or her identity. Identity refers to a composite definition of the self; it is the person we think we are (Christiansen, 1999). The term *authenticity* encompasses the notion of being genuine and real, which involves being oneself, honestly, in one’s relations with his fellows (Slunt, 1989). In this discussion, the term *authentic identity* will be used to describe the identity a person is living out when there is a consistency between his or her worldview beliefs and actions.

The therapists in this study continue to develop and live out their authentic identities through professional practice. For example, participants in this study talked about the relationship between her or his work and who they were as individuals by saying, “OT is who I am, and what I do”, that it’s “a part of my involvement in humanity”, “I’m a born OT” and “I am raising my kids as an OT”, “my approach to working with patients is who I am as a person”, work everyday is “a part of my religion”, and described a “symbiosis” saying that “everything I do reflects upon my work, and I think that everything that happens to me at work reflects on who I am as a person.”

For the participants in this study, working as an occupational therapist was often understood as an expression of authentic identity. This thought is captured by Mindell (1995) who suggests that because of the relationship between her work and beliefs that “she is no longer ‘doing’ therapy or applying techniques, but living and manifesting her deepest beliefs in all that she does” (p. 50).
McAdams (1997) emphasizes that we actively create our identity through how we act on the world in which we live. He goes on to say that in creating a life story we seek to construct a sense of coherence to our identity that makes sense to ourselves and to others. It has been suggested that an authentic person is more self-accepting, and comfortable with whom they are (Slunt, 1989). Each therapist in this study valued work as a means of expressing his or her identity, however the different worldview beliefs that each held influenced the clinical reasoning process.

When therapists described the influence of worldview beliefs on clinical reasoning they used remarkably similar language. Commonly used concepts or words include “enabling the client”, “holism in practice”, and “connecting with the essence of the client.” However, each therapist defined and enacted the concepts that are a part of the language of occupational therapy in a unique manner, which revealed personally constructed meanings. For example Sally defined enabling a client as “showing them how to listen to the inner voice,” while John conceptualized enabling as “mastering the environment through occupations.” These constructed meaning influenced how each of the participants envisioned and enacted their role as a therapist. In Sally’s case, she believes that injury or illness is a physical manifestation of a failure to listen to the inner dimension of the body. Therefore she believes that enabling in occupational therapy requires her to demonstrate to a client how to connect with this dimension so that they will no longer have the symptoms of an illness. In contrast, John believes that clients by “mastering their environment” are able to find meaning in life by reconnecting with the person they were before they suffered an injury or illness. In order to facilitate this process, he teaches individuals how to maximize the abilities they still have.
In an attempt to create coherence in identity, work does not just provide an opportunity for therapists to express their worldview. A dynamic relationship exists between worldview beliefs and work. Therapists in this study shared examples of experiences that confirmed and refined their worldview beliefs. John talked of previous clients who have come back and give him updates on their progress. These clients talk about the jobs, hobbies, and roles they have been able to resume, not about how much stronger an arm or leg has gotten. For John this confirms his worldview belief that his role as an occupational therapist is to enable clients "to find meaning and purpose in life by having their human essence come out again so they are able to be who they want to be in a positive way." The manner in which John facilitates this expression of human essence for his clients is by using occupations. While this example demonstrated a work experience that confirmed a therapist's worldview beliefs, other information from participants in this study suggests that work experiences also have caused therapists to reexamine and refine existing beliefs.

For example, Jane in her initial years of practice saw effective occupational therapy as learning and applying therapeutic techniques appropriately to a client to help them heal. Through her experience in working with low level brain injury patients she described a shift in her beliefs about the role of an occupational therapist. She explained this shift by saying "it wasn't just a job anymore, it wasn't just about the techniques, instead it was about really honing in on caring for people and helping them deal with tragedy." For Jane this realization was a significant event in her development as a therapist, and it influenced the way she constructs the clinical reasoning process in occupational therapy.
Connecting with others

The expression of worldview beliefs in occupational therapy was also evident in how each therapist connected clients. Participants in this study expressed a belief that the ability to enter a relationship with clients was one of the most important contributions they made to the person’s recovery. They felt that the nature of relationship formed with clients was unique not only to their identity but also to occupational therapy. Therapeutic relationships comprise the non-technical, interpersonal aspects of providing medical care (Rosa & Hasselkus, 1996). It has been suggested that this relationship is essential to engaging the patient in the therapy process and directly influences the patient’s outcomes either positively or negatively (Gilfoyle, 1989; Peloquin, 1990; Rosa & Hasselkus, 1996).

Several authors in occupational therapy consider the therapist-patient relationship to be the heart of practice (Hasselkus, & Dickie, 1990; Gilfoyle, 1980; Peloquin, 1990). However, professionals in health care were traditionally expected to maintain a distance in relating to clients in order to remove the contaminating effect of personal influence and to enhance credibility (Rosa & Hasselkus, 1996). This is often an ongoing expectation for the professional relationships that occupational therapists form with clients. For example, the AOTA’s (1994) code of ethics states, “occupational therapy personnel shall avoid those relationships or activities that interfere with professional judgment and objectivity.” However, in occupational therapy, the recent emphasis on client-centered care, may help move away from traditional understandings of professional objectivity. The client-centered therapist understands the meaning of an illness from the client’s perspective, is thought to enable the therapist to establish a therapeutic relationship that
maintains this objectivity. Fleming (1991) refers to this process as interactive reasoning in which the therapist enters a personal, engaged stance with clients.

In this study each participant described a relationship with clients that went beyond the objective disengaged perspective of the therapeutic relationship. Sally states “my belief system allows me to interact with clients not as an illness or sickness, but as equals who are in a relationship that allows us to learn from each other as we undertake this process moment by moment.” She describes this relationship as “allowing us to sit together and kind of gel and make that same supposable treatment pathway become a unique pathway.” John also talks about being with clients and connecting with their essence in a manner that transcends an objective relationship. He describes this connection by saying “I immerse myself in an activity and allow myself to feel what is going on with that person. I think that my own beliefs are part of what I look at connecting with the essence of being human. I see myself as paying tribute to that essence or god in my clients.”

In connecting with clients the stance of the therapists in this study more closely reflected what Peloquin (1995) suggested in saying, as we are “doing with” persons, we are performing a unique act of “being with” them (p. 27). Understood in this sense, occupational therapy becomes an experience that is lived between human beings. As humans, we live in an interpretive world and the relationships we form with others is an interpretation based on our experiences and understanding. Stenger (1991) in talking about interpersonal relationships argues, “The interpreter cannot step out of his own horizon of intelligibility and adopt the author’s [client’s]. The interpreter can only try to assimilate the author’s text into his own horizon, by widening his own conceptions of
meaningfulness” (p. 33). Perhaps this explains why each individual’s worldview belief system shapes and is shaped by our relationships with others and our experiences. At the same time therapists are often left in a situation where they are attempting to negotiate the apparent inconsistency between maintaining an objective professional relationship with clients, while at the same time creating the lived experience of being with clients in therapy.

**Implications for Future Occupational Therapy Practice**

According to Brookfield (1987) “identifying and challenging the assumptions by which we live is central to thinking critically” (p. 89). Brookfield goes on to suggest (1987) “assumptions that are so internalized that they are perceived as second nature or common sense is problematic precisely because of the familiarity of these ideas (p. 90). Through this research, it became clear that although worldview beliefs do influence clinical reasoning, occupational therapists continue to struggle to identify and explicate the tacit personalized dimensions of clinical reasoning. This difficulty was evident in the relative use of language that therapists’ used to described their clinical reasoning.

In order to continue explicating the connection between worldview and practice it will be important to examine the issue of language more closely. As a result of the unique knowledge base upon which a profession draws, language is the medium that we use to describe our experiences cognitively (Bishop & Scudder, 1991). We need to learn how to talk about the intrapersonal dimension of clinical reasoning to one another in a language that is understood by our colleagues in occupational therapy. Almost certainly a common cursory language exists, but it is superficial and imprecise. In order to develop this language it is necessary to craft a common understanding that will increase
therapist’s ability to explicate and reflect upon the intrapersonal aspects of the clinical reasoning process.

The challenge of explicating the influence of worldview on clinical reasoning was also evident in the manner that therapists’ described their clinical practice in relationship to what they viewed as effective occupational therapy. When asked to give examples of what constituted effective occupational therapy practice, therapists often had difficult expressing their thoughts directly. Instead they often gave examples or relayed situations that illustrated practice that was not consistent with their personal beliefs. Vickers (1978) suggested that in judging the qualities of things, we can recognize and describe variations from a norm more easily and clearly than we can describe the norm itself. Describing variations from the norm rather than the norm itself suggests that, while therapists may not be able to easily pinpoint exactly what practice is that is consistent with assumptions of the profession, they are able to identify practices that are outside of occupational therapy’s professional identity. Further development of this ability may be a valuable tool to developing consistency in our profession’s identity. Identifying professional practices that contradict occupational therapy philosophy can serve as a starting point for more clearly defining what constitutes a more appropriate course of action in clinical reasoning.

Despite the difficulty of expressing the relationship between worldview and clinical reasoning, clearly a relationship does exist. Literature suggests that a relationship between professional and personal values is considered desirable and even critical to good occupational therapy practice (Crepeau, 1991; Fleming, 1991; Peloquin, 1990; Rosa & Hasselkus, 1996). This relationship has been identified as a means to prevent burnout
and attrition by making work more satisfying and personally meaningful (Peloquin, 1994; Rosa & Hasselkus, 1996). Blending of professional and personal worldview beliefs allows a therapist to form a composite authentic identity and has great potential to improve the meaning that therapists find in clinical practice. However, a profession is demarcated from other fields by its unique domain of practice. It becomes important for members of a profession to incorporate personal and professional identities within the parameters of that field. In order to examine how personal beliefs can be ethically integrated into practice, subsequent discussion will examine the issue of professionalism as it relates to occupational therapy.

The Issue of Professionalism

Occupational therapists have to consider the issue of professionalism as the field “strives to develop and implement strategies to meet the changing financial and structural demands of the current health care industry” (Burke & Depoy, 1991, p. 1027). Burke & Depoy (1991) go on to suggest that there are two important benefits to professional identity. The first benefit is in assisting others within the profession and those aspiring to the profession in emulating appropriate practice. The second benefit is in defining the uniqueness and justifying the worth of that profession to those outside of that profession which affects the credibility of our profession to other health care providers, third party payers, and the general public. Two common criteria that define a profession include having a distinct body of theoretical knowledge on which its practice is based and providing an important service to society. (Burke & DePoy, 1991; Kyler-Hutchison, 1988; Zerwekh & Claborn, 1997). A profession is based on shared beliefs and values
about what constitutes practice and what tasks and problems the profession is designed to address.

Occupational therapy has made great strides in establishing a strong professional identity evident through an increased effort to explicate its philosophy and values (Fondiller, Rosage, & Neuhaus, 1990), clinical reasoning processes (Schell, 1998), assumptions inherent in practice (Reed & Sanderson, 1999), and by establishing the academic discipline of occupational science (Clark, Wood, & Larson, 1998). While the development of a professional identity is an ongoing process, it involves a continuous examination of practice to identify its theoretical principles, and foundational knowledge and the characteristics that distinguish excellence in practice (Schon, 1983, Yerxa, 1983).

In contrast to the definition of professional identity many researchers suggest that experienced clinicians construct personal theories that are based more on experience and internal belief structures (Kagan, 1992; Minsky, 1977; Munroe, 1996; Slater & Cohn, 1991; Strong, et. al 1995). DePoy (1990) suggests that expert therapists “seem to have transcended the use of theory as a guide for professional activity” (p. 421). Instead, therapists rely on a unique and intuitive “knowing in action stance” to make clinical decisions (Mattingly, 1991). This process of knowing in action is based on individual’s normative judgments by which they recognize actions as right or wrong and, as a result, clinical reasoning becomes a tacit, subjective process. In this study therapists seem equally interested in practicing occupational therapy in the manner that they have uniquely constructed and also referred to an instinctual knowing in the clinical reasoning practice. While knowing in action can provide expert therapists with a high level of efficiency in practice it may also raise concerns in occupational therapy.
Critical Reflection on Worldview Beliefs

Critical reflection has been identified as crucial and has been equated to learning in professional reasoning (Brockett, 1998; Cramptom, 1994). Critical reflection means to assess critically the presuppositions on which thinking is built (Mezirow, 1990). It has been established through earlier discussion that a professional's worldview frequently results in narrowly constraining his or her thinking and that without being confronted with alternative that he or she finds it hard to critically examine this worldview (Brookfield, 1987; Kitchner, & King, 1990; Mezirow, 1991; Schon, 1987). Warnke (1987) suggests that a gradual development of understanding only becomes possible when we continually question our prejudices and adjust our assumptions, allowing us to move to richer, more developed understandings. The process of critical reflection is such a process and it results in making a new or revised interpretation of the meaning of an experience that guides subsequent understanding, appreciation, and action. However, it can be emotionally challenging as well as personally threatening to embark on this process (Brookfield 1987; Mezirow, 1990). To critically examine the assumptions one holds in a worldview is to admit that beliefs, and by extension a professional practice, may be founded on a less than coherent foundation (Brookfield, 1987, Kitchner & King, 1990). There are implications of this need to critically examine the worldview assumptions that therapists hold not only for the education of future professionals, but also for professionals that are currently practicing.

To encourage critical reflection in practice, schools of occupational therapy need to continue to teach didactic portions of their curricula while at the same time addressing assumptions inherent in the content. Failure to do so may lead to therapists implementing
their own beliefs without examining the assumptions inherent in them and determining if they are consistent with the core assumptions of occupational therapy.

This is also true of professionals already practicing. If beliefs are related to practice, and more particularly if beliefs drive practice, then unless therapists critically examine their practice, the tendency to interpret experience in light of existing beliefs may further entrench inconsistent beliefs (Schon, 1987). Staff development that focuses solely on clinical practice may not be successful in effecting change unless the therapists' beliefs and the theories underlying practices are also explored. Continuing education programs incorporating teaching strategies that address both the cognitive aspects of theory and the assumptions inherent in them may prove to be a more effective in creating a unified professional identity.

**Limitations**

While this study provided much information in terms of the relationship between worldview beliefs and clinical reasoning for therapists, there are limitations with this study. Most of the limitations related to this study were related to sample size, criteria for sample selection, sample diversity and geographic area. First, the sample is limited in regards to size. Only three therapists were interviewed for this study. Second, all the participants practiced in the same setting (inpatient rehabilitation) and the sample was made up entirely of white middle class mid-western Americans. Because of these concerns the sample the findings of this study may not be reflexive of clinical reasoning in the larger population of occupational therapists including those practicing in other settings.
Another apparent limitation of this study is related to the nature of the sample selection of "expert" therapists. In occupational therapy literature "expert" therapists are characterized by subjective qualities without clear definitions. As a result the participants were selected based on individuals' perceptions of those consistent with the criteria.

A final apparent limitation of this study was related to the analysis of data. Due to time constraints, the participants were not given the opportunity to provide feedback after analysis of all interviews was completed. This prevented additional information and clarification from the participants regarding the phenomena being studied.

**Suggestions for Future Research**

The findings of this study underscore the importance of continued research to examine the personal contexts of clinical reasoning in occupational therapy. Possible areas for further research include repeating the study using a larger and more demographically diverse participant group. Studying therapists working in a variety of different settings may also lend valuable insight into how worldview influences clinical reasoning in occupational therapy. Research should also include investigating how worldviews are formed and altered, how to best elicit worldview reflection in occupational therapy, and the effects of particular belief systems on practice in occupational therapy. Because of the difficulty therapists had in articulating the intrapersonal components of clinical reasoning, perhaps future research would be more effective by focusing on eliciting stories rather than asking therapists to explain abstract concepts related to clinical reasoning.
Conclusion

As a profession, occupational therapy is concerned with restoring clients' identities by enabling them to engage in meaningful daily occupations (Christianson, 1999). In order to do this effectively, therapists need to be comfortable with their worldview both as professionals and as individuals. Karl (1992) states “in order to be there for others, we also need to be rooted in sources that nourish and animate the spirit of our being” (p. 10). The expression of worldview beliefs resulting in the creation of an authentic identity may provide that nourishment by connecting therapists with their work in a meaningful way. However, it is crucial that in enacting the work of occupational therapy in this personally fulfilling manner, that therapists do not abandon their professional identity in the process. Rodgers (1983) describes the necessity of balancing the complexity of clinical reasoning by stating “the clinician functions as a scientist, ethicist, and artist. The scientific ethical and artistic dimensions of clinical reasoning are inextricably entwined, and each strand is needed to strengthen the line of thought leading to understanding” (p. 615).

Critical reflection on the assumptions inherent in personally held worldview beliefs is one way to balance the complexity of clinical reasoning. Both as individuals and as a profession, it is necessary to have the courage to openly undertake the process of critically examining worldview beliefs. It is not enough to simply assume that experienced therapists know what to do in practice. While this tacit knowing may contribute to individual knowledge and practice of occupational therapy, it does not allow for transferring this knowledge to developing practitioners. Through persistent research and discussion it is necessary to continue to develop language and tools that allow
therapists to critically reflect on the worldview beliefs they enact in professional practice. Critical reflection on worldview beliefs will allow therapists to create a consistency between personal beliefs and professional practice. Only then will occupational therapists be able to maintain a truly authentic identity, which encompasses the ethical practice of occupational therapy and authentic expression of personal values.
References


Appendix A

Semi-Structured Interview Guidelines

Overarching Question: How do your personal beliefs about the human nature influence how you practice occupational therapy?

Through our conversations, I am interested in understanding how your worldview beliefs regarding human nature influence your practice as an occupational therapist. As a part of this first interview I will ask you questions about your history and background related to OT, and about how you perceive human beings. In the subsequent interview we will further explore the influence you feel that these beliefs have in your professional practice and discuss specific experiences where this occurred. The audiotape will be used to ensure that I am accurately reporting your statements. I will also take some notes as we talk to write down key statements and information that I may wish to come back to in order to clarify. Again I want to assure you that this entire conversation is confidential, and you identity will not be connected to these interviews in any way.

Interview # 1

1. History and Background
   Tell me the story of how you became an OT.

   What was it about your own personal background, interests, or beliefs that seemed to draw you to the profession? Initially and now.

   Looking back over your “life” as an OT, what experiences have been really important to you, and Why?

2. Beliefs about the Human
   Please complete the following sentence; An individual is valuable as a person because______.

   Can you describe for me your view of a human?

   What characteristics do people share?

   What are the things that are worth accomplishing in life? Is the manner in which we go about accomplishing these things important?

   What is our purpose or what is meaningful in life as human beings? Is this purpose or meaning the same for everyone? Where does this belief come from?

   Do you have beliefs about what is ultimately good and true? What are these beliefs? Have they changed?
Do you believe that there is an essential nature or spirit to a human being? What happens to this spirit or essential nature when one dies? To what do you attribute that belief?

**Interview # 2**

1. **Influence of Personal Beliefs on Professional Practice**

What is the most important thing you do for your clients-patients?

From the way that you practice OT what would your clients/patients say is most important to you?

In the previous interview we discussed your beliefs about the nature of the human. Do these beliefs influence how you practice OT? How?

Do you hold other personal beliefs that inform your practice as a occupational therapist? What are these beliefs? In what way do they impact how you go about your work as an OT?

How is your practice as an OT unique or different from other OT’s? What causes you to practice in this way?

Does the way you go about your work as an OT reflect who you really are? How?

Tell me about an experience(s) in your practice that has validated your beliefs about the value of occupational therapy? What was your thought process? What actions did you take?

Tell me about an experience(s) in your practice that challenged your beliefs about the value of occupational therapy? Again what was your thought process? What actions did you take? Did this change the way you think about or practice OT? How?

* Supplementary probing questions may be generated during each interview. Additional questions will be added to the second interview based on the participant’s responses during the first interview.
Appendix B
Consent Form

You are invited to participate in a research study entitled "The Influence of Occupational Therapists' Worldview on Clinical Reasoning and Action: A Qualitative Study". The purpose of this study is to determine how occupational therapists experience the link between their views of the world and how they enact clinical practice. The knowledge gained is expected to help provide a more thorough understanding of the clinical reasoning process in occupational therapy.

I also understand that:

1. participation in this study will involve two 60-90 minute audiotaped interviews regarding how I experience the link between my view of the world regarding human nature and clinical practice as an occupational therapist.

2. I have been selected because I am a currently practicing occupational therapist who meets the criteria within the field to be considered an "expert". These Criteria include:
   - experience in the field (4 years minimum)
   - commitment to the profession (values professional development)
   - knowledge of theory (related both to research and practice)
   - the ability to articulate rationale for decisions.

3. it is not anticipated that this study will lead to physical or emotional risk to myself.

4. the information I provide will be kept strictly confidential and the data will be coded so that identification of the individual participants will not be possible. All audiotapes will be destroyed following transcription of the interviews.

5. a summary of the results will be made available to me upon my request.

I acknowledge that:

"I have been given an opportunity to ask questions regarding this research study and that these questions have been answered to my satisfaction."

"In giving my consent, I understand that my participation in this study is voluntary and that I may withdraw at any time by contacting the researcher, Matt Mekkes."

"I hereby authorize the researcher to release the information obtained in this study to scientific literature. I understand that I will not be identified by name."

"I have been given Matt Mekkes' phone number so that I may contact him at any time if I have questions."

"I acknowledge that I have read the above information and been given a chance to ask questions, and that I agree to participate in this study."

________________________  _________________________
Witness                  Participant Signature

______ Date              ______ Date
I am interested in receiving a summary of the study results

Matt Mekkes, Researcher
Home 616-677-1929

Barb Hooper, Committee Chair
GVSU 616-331-3356

Paul Huizenga, Human Subjects Research Review Board
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