University of Alberta

Doing occupation:
A narrative inquiry into occupational therapists' stories of occupation-based practice

by

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Dedication

This dissertation is dedicated with love to my parents, Dr. Ronald A. Burwash and Ruth W. Burwash, who taught me most of the lessons I live by today. Thank you for all the experiences that we have shared, and are sharing, and for all the stories you have told me, along the way.

Abstract

This narrative inquiry explores occupational therapists' experiences of *doing occupation* – attempting to work in ways that are congruent with their professional commitment to using activities (*occupations*) as therapy, and focusing on enabling clients to participate in their valued occupations as the goal for therapy. The inquiry emerged from my own experiences as an occupational therapy clinician, manager and educator. Four occupational therapists with diverse experiences as occupational therapists shared their experiences of doing occupation during individual conversations with me and group discussions, over an eleven-month period in 2010 - 2011.

Field texts included tape-recorded and transcribed conversations of individual and group discussions, field notes related to these conversations, a digital story created by one participant, journal entries, research poems and images, and collages made by two of the participants. Research texts were composed with each participant, in the form of narrative accounts that inquire into participants' experiences, using the three-dimensional narrative inquiry space with dimensions of temporality, sociality, and place.

Four wonders related to *doing occupation* that I marked as I looked across the four narrative accounts for resonance and for bumping up places are discussed further: (1) reaching for the real in practice, (2) identities, (3) complex issues related to the heart, mind and soul of occupational therapy (Wood, 2004) and, (4) participants' strategies for resisting or escaping

systemic pressures to practice in ways which are not compatible with their personal practical knowledge. These were explored through further inquiry into participants' experiences and through looking at the occupational therapy/occupational science literature. The personal, practical and social implications of this inquiry are discussed – how my practices as an educator will change, how educators and clinicians might be able to use this inquiry to reflect on their practice experiences, and why and how narrative inquiry may provide a valuable methodological approach for occupational therapy and occupational sciences researchers.

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Finally, I would like to thank my father, Dr. Ronald A. Burwash, to whom, along with my mother, this dissertation is dedicated. His living of the art and science of scholarly work, his dedication to teaching, his integrity, his love, his faith that I would become the *next* Dr. Burwash in the family, his support and encouragement to the other doctoral student in my household, have brought me to this point. I miss you every day, and I am so grateful to have had such a father.

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Chapter One: Coming to inquire about "doing occupation"

> *… this was the fundamental underpinning of his whole rehabilitation. He really needed to feel he could make change for himself. That it was okay to try, that was safe to try, that he was in control of his life and we had a little chat about … I asked "do you want to go make coffee while I'm writing stuff up; do you want to go put the kettle on and we can have some instant coffee?" Which was quite nice in that testing area in [the clinic] cause you could do that. And he had never done that…I said, "Well do you think you can?" He thought he could, so he went and made coffee. Well that was, again, was a 1st for him… And I said to him "There are healing forces in the world but you have to touch them, and when you're making coffee and when you're touching the kettle and you're touching the cups and you're touching the water, you're touching a healing force" [tears up and voice chokes] … But he came the next time and I think there was a delay of about a week and he came in bursting with pride to tell me that he had taken out the garbage, which wouldn't have meant much to anybody else but this was something that, it isn't something he would have even have thought of doing before. But he was engaging again; it was touching the world and engaging with life.* (Katherine, research participant, personal communication, May 2011)

My narrative inquiry is about occupational therapists and their experiences of using therapeutic activities or *occupations* in and as therapy. Katherine's story about using the occupation of making coffee with her client, and her client's pride in his subsequent completion of a routine occupation at home, provides a window into the practice of one occupational therapist and an introduction to a core concern of occupational therapy – using *occupations* as therapy to help clients improve or maintain their health and thus their ability to engage in life. Occupation-based practice can be a challenge for occupational therapists, particularly when working in healthcare settings that may not readily provide clients with opportunity to engage in their

typical daily occupations. While these difficulties are acknowledged as an ongoing concern for therapists (Aiken, Fourt, Cheng and Polatajko, 2011; Colaianni, 2012; Edwards and Dirette, 2010), occupation is identified as the key therapeutic medium of the profession and working in an occupation-based way is seen as central to practice (American Occupational Therapy Association, 2005; American Occupational Therapy Association, 2008; Canadian Association of Occupational Therapists, 2008).

This chapter starts by defining occupation (and the associated term co-occupation), describing occupational therapy and exploring the terms "occupation as means", "occupation as ends", and "occupation-based therapy" through a brief review of the occupational therapy literature. The discipline of occupational science (OS) is also briefly described, given that some of the ideas that are discussed in this inquiry come from occupational science research. I will tell the story of how and why this inquiry came to be through sharing some of my own career and practice stories and inquiring into these stories. Finally, I will discuss why an inquiry into occupation-based practice is important and describe the research puzzles that arose from inquiring into my practice and reviewing the professional literature.

What are occupation and co-occupation?

Defining occupation

Occupational therapists around the world have defined occupation in a variety of ways. In Canada, occupation is seen as being:

> activities … of everyday life, named, organized and given value and meaning by individuals and a culture. Occupation is everything people do to occupy themselves, including looking after themselves … enjoying life … and contributing to the social and economic fabric of their communities (Law, Polatajko, Baptiste and Townsend, 1997, p. 32).

In the UK, a Delphi study completed by Creek (2006) produced a definition of occupation as:

> An activity or group of activities that engages a person in everyday life, has personal meaning and provides structure to time. Occupations are seen by the individual as part of his/her identity and may be categorized as self care, productivity and/or leisure (p. 205).

The European Network of Occupational Therapy in Higher Education (ENOTHE) defines occupation as "a group of activities that has personal and socio-cultural meaning, is named within a culture and supports participation in society. Occupations can be categorized as self-care, productivity and/or leisure" (ENOTHE, n.d.). According to the American Occupational Therapy Association (AOTA) occupations can be defined as "activities having unique meaning and purpose in a person's life … central to a person's identity… how one spends time and makes decisions" (AOTA, 2002). Common to these and other definitions is the idea that occupations are activities that have or provide meaning to an individual, organize that individual's use of time and provide the means for participation in the daily life of their community.

The terms *occupation* and *(meaningful) activity* are sometimes used

interchangeably; however occupational therapy theorists have differentiated between occupation and activity. For instance, Pierce (2001, p. 138) describes occupation as a "personally constructed, one-time experience within a unique context" in contrast to an activity, which she suggests is a "more general, culturally shared idea about a category of action." Fisher (1998) suggests that occupational therapists consider the "ecological relevance, source of purpose, source of meaning and focus of intervention" to evaluate what they choose to have clients engage in as therapeutic interventions. So, for instance, in placing a possible intervention on the ecological relevance continuum, is it closer to an exercise or therapeutic occupation? In other words, is the client being asked to do a contrived exercise/activity or is it something s/he would typically do in her/his day-to-day life within the environments in which s/he lives, works and plays? Is the therapy related more to therapist or to client sense of purpose and source of meaning? Is the focus remediation of an underlying deficit or enhancing occupational performance?

Polatajko et al. (2004) proposed a taxonomy for occupation that starts at the most basic level with voluntary movement, and moves upwards to movement pattern, action, task ("an action or set of actions involving tool use"), activity ("any set of tasks"), then to occupation, which they describe as "a set of meaningful activities, performed with some consistency or regularity…named for the predominant or primary activity." This taxonomy has been critiqued by Paley, Eva and Duncan (2006) who suggest that classification schemes such as this are built on faulty assumptions about

human behavior and suggest instead an "in-order-to analysis" to explain the connections between goals and what has to be accomplished to achieve those goals, rather than continuing to break occupations into smaller and smaller bits. The example they provide is the goal of doing home renovations. An "in-order-to analysis" determines what step is needed first, in order to be able to do what is needed next, in order to be able to do what follows from that, and so on. For instance, in their example, sawing wood, in order to make a mortise, in order to make a table, in order to complete a home renovation project (p. 166 – 167). These diverse actions are not placed on a hierarchy, as they would be by individuals viewing this through Polatajko et al.'s (2004) taxonomic lens.

When occupational therapists talk about practice, the differences between working at the task/activity level and working occupationally are sometimes summed up by some occupational therapists in the phrase "cones and pegs" (Asher and Newman, 2000; Schell and Braveman, 2005). Stacking cones and putting pegs into pegboards are two tasks/activities used for upper extremity rehabilitation. These (perhaps) purposeful, but almost likely not personally meaningful, activities have been commonly used in some settings, but might not be considered to be occupations, or at least not therapeutic occupations, based on the definitions cited above.

In this inquiry participants have sometimes used the terms occupation and activity interchangeably. The intent, however, was to explore therapists' use of *occupation,* meaning personally constructed/co-constructed

experiences within the specific context of a therapeutic session or sessions, using clients' occupational needs, preferences and past experiences to guide therapy.

Defining co-occupation

A more recent development in the ongoing debates within occupational therapy about defining occupation (Paley, Eva and Duncan, 2006; Polatajko et al., 2004) is the suggestion that occupational therapists also need to consider *co-occupations.* This term, coined by Pierce in 1990 (Pierce and Marshall, 2004), came from the then-new discipline of occupational science. Pierce defined co-occupations as:

> Co-occupations are the most highly interactive types of occupation, in which the occupational experiences of the individuals involved simply could not occur without the interactive responses of the other person or persons with whom the occupations are being experienced… They are a synchronous back and forth between the occupational experiences of the individuals involved, the action of one shaping the action of the other in a close match. (Pierce, 2003, p. 199)

Much of the discussion about co-occupation comes from research exploring parent/child relationships (Olsen, 2004; Price and Miner, 2009), although Fanchiang (1999) looked at co-occupation in the lives of persons with Parkinson's disease. Pikens and Pizzur-Barekow (2009) review this discussion and suggest that co-occupation occurs when "two or more

individuals engage in an occupation which becomes transformed by aspects of shared physicality, shared emotionality and shared intentionality" (p. 155). They provide an example of a parent helping a child to learn to ride a bicycle. The parent and child are both physically involved as the parent steadies the bicycle and then runs behind the child as she begins to peddle and gain speed. There is shared emotionality as the parent and child anxiously or excitedly start to teach and learn bike-riding skills and then celebrate when these skills are gained. There is shared intentionality in that both parent and child intend that the child will learn how to ride the bicycle. To date there has been very little discussion about co-occupations that might involve client and therapists, although some researchers suggest that occupation and co-occupation emerge in therapy as clients and therapists emplot "healing dramas" (Mattingly, 1998) or engage in meaning making about possible futures (Price and Miner, 2007).

What is occupational therapy?

Occupational therapy is:

> …the art and science of enabling engagement in everyday living, through occupation; of enabling people to perform the occupations that foster health and well-being; and of enabling a just and inclusive society so that all people may participate to their potential in the daily occupations of life. (Townsend and Polatajko, 2007, p. 372)

> …the therapeutic use of occupations, including everyday life activities with individuals, groups, populations, or organizations to support participation, performance, and function in roles and situations in home, school, workplace, community, and other settings. Occupational therapy services are provided for habilitation, rehabilitation, and the promotion of health and wellness to those who have or are at risk for developing an illness, injury, disease, disorder, condition, impairment, disability, activity limitation, or participation restriction. (American Occupational Therapy Association, 2011)

> …a client-centred health profession concerned with promoting health and well being through occupation. The primary goal of occupational therapy is to enable people to participate in the activities of everyday life. Occupational therapists achieve this outcome by working with people and communities to enhance their ability to engage in the occupations they want to, need to, or are expected to do, or by modifying the occupation or the environment to better support their occupational engagement. (World Federation of Occupational Therapists, 2011)

Whereas these definitions (from Canada, the United States and from the organization representing occupational therapy on the global stage) may vary in some ways, a common thread running through all three is that

occupational therapy entails the use of *occupations/activities* to promote health and participation for individuals, families and communities.

Occupational therapy came into being at the turn of the 20th century in the United States, United Kingdom, and Canada. The roots of the profession are intertwined with concurrent developments in American and British philosophy, education and three social reform movements – moral treatment of persons with mental illness, the Arts and Crafts movement, and the establishment of "settlement houses." It is in this intertwining that perhaps occupational therapy can be said to have gained its "two-body" practice (both biomedical and phenomenological) (Mattingly & Fleming, 1994). Here too may lie the roots of this practice that combines both rational and Romantic ideals (Hocking, 2004), and holds both pragmatic and structuralist discourses (Hooper and Wood, 2002). Occupational therapy has been identified as a provider of both health and social care, and as a profession both conventional and crusading. This multi-stranded identity, which holds within itself many dichotomies, is evident in contemporary occupational therapy discussions about identity, and provides both possibility and puzzle for those within and outside of the profession.

Hooper and Wood (2002), along with Breines (1986, 1987), Cutchin (2004) and Ikiugu and Schultz (2006), suggest that the founders of the occupational therapy profession in the United States were particularly influenced by the pragmatic philosophy of John Dewey, William James and others. Breines comments that "pragmatic principles were placed in the

medical arena as occupational therapy" (p. 92). Ikiugu and Schultz (2006) reviewed occupational therapy literature and the works of prominent pragmatists (Pierce, James, Dewey and Mead) to explore commonalities of assumptions, principles and values between the two. Three themes were identified as consistent with occupational therapy: occupation, activity and purposefulness. Ikiugu and Schultz (2006) find these to be consistent with the themes of action/activity, as well as the importance of "beliefs, instrumentalism and choice" (p. 90) that they found in their reading of the works of these American pragmatic philosophers.

Many leaders in occupational therapy have identified the need for occupational therapy to turn away from a biomedical perspective and return to a focus on being occupation-based. Yerxa's (1967) call for "authentic occupational therapy," Shannon's (1977) discussion of the derailment of occupational therapy, Kielhofner and Burke's (1977) discussion of paradigm shifts in the profession, Friedland's (1998) discussion of the "awkward alliance between occupational therapy and rehabilitation", Molineux's (2004) "*Occupation in occupational therapy: A labour in vain?*" all reflect a concern about the erosion of the occupational foundations of the profession. Hooper (2006) asks us to consider if our ability to re-gain our focus on occupation, participation and health rests on epistemological transformation to Kegan's "fourth order knowing" where occupational therapy can become self-authoring, rather than being subject to others' definitions of the profession (p. 16).

Occupation-based therapy: occupation as means/end

That the *end* of occupational therapy is directed towards individuals, families, organizations or communities being able to participate in their chosen occupations is almost universally accepted within the rhetoric of contemporary occupational therapy practice. Enabling participation or engagement, rather than improving or maintaining body function, fostering independence, or other elements that may or may not lead to human doing, being and becoming, is considered the key outcome of effective occupational therapy intervention. "*Occupation as means*" refers to the use of occupations as and in therapy. Within this inquiry, occupation-based practice refers to both occupation as means and occupation as ends.

What is occupational science?

In a review of the history of occupational science, Pierce (2012) describes occupational science as an academic discipline that arose both from the work of American occupational therapy academics, many of them from the University of Southern California, with E. Yerxa as an influential early proponent of this new field, and from work done in Australia by A. Wilcock. Initially occupational science was proposed as a discipline that would contribute to occupational therapy practice through a focus on research about occupation, much as the basic science discipline of anatomy supports medical practice. The Canadian Society of Occupational Scientists

defines occupational science as: “the study of human occupation. It is a basic science dedicated to the understanding of human occupation, using both qualitative and quantitative methods of inquiry” (Canadian Society of Occupational Scientists, 2010). Over the almost 20 years of its existence as an emerging discipline, it has become somewhat more inter-disciplinary, although many occupational scientists still have a background in occupational therapy (Pierce, 2012). Clark and Lawlor (2009) suggest that, as occupational science has developed, the discipline has moved beyond labeling research as either basic or applied, and re-affirm the link between occupational science and occupational therapy. Many occupational therapy educational programmes include some exploration of occupational science within their curricula, and there are numerous post-professional graduate programmes with an occupational science focus. Pollard, Sakellariou and Lawson-Porter (2010) and Pierce (2012) note that there have been some tensions between the profession of occupational therapy and the discipline of occupational science. It is beyond the remit of this chapter to discuss these tensions in depth, but important to acknowledge that they exist. While this inquiry focused on occupational therapy practice, some of the ideas that are discussed within this inquiry, such as co-occupation and the link between Deweyan pragmatism and occupation, are those which have been discussed in both the occupational science and occupational therapy literature. Some of the scholars who label themselves as occupational scientists and whose work has influenced this inquiry include Cheryl Mattingly, Malcolm Cutchin, Doris

Pierce and Pollie Price. As an occupational therapist, I have found these ideas useful and thus they have found their way into this inquiry.

Why inquire about occupation-based practice?

Occupational therapists say that they focus on facilitating participation in purposeful, meaningful activities or "occupations" that individuals or communities want or need to do to enable health and well-being. As discussed earlier, this focus on occupational participation as the *end* or purpose of therapy is articulated in many current definitions of occupational therapy and in practice documents developed by various professional bodies as well as by occupational therapy theorists. In addition to a focus on participation in occupations as the *end* of therapy, many occupational therapists also state that the use of occupations as *means* within therapy is a core element of occupational therapy practice. These two elements together, occupation as means and as end, can be seen as *occupation-based* practice. Although there is some agreement within the profession that most occupational therapists consider the occupational *ends* of therapy while working with their clients, there is ongoing discussion about the degree to which it is possible for occupational therapists to use *occupations as means*, particularly in biomedical settings where the focus is often on addressing underlying performance components, for instance range of motion or strength or cognitive functioning (Fisher, 2003; Rebeiro, 2000). Some of the

tensions of occupational therapy practice are illustrated in the following quotes:

> The wide and gaping chasm which exists between the complexity of illness and the commonplaceness of our treatment tools is, and will always be, both the pride and anguish of our profession. (Reilly, 1962, p. 2)

> Despite a professional commitment to occupation-centered treatment, I have not found it an easy task either in the experiences described by my colleagues and students, nor in my own practice. Recent discussions with students returning from Level I fieldwork revealed observations by several that 'no-one is doing occupation out there'. (Gray, 1998, p. 354)

> When I hear from these people, I wonder, 'What happened to the occupation in occupational therapy?' for when I pursue the topic more deeply, I learn that: (i) there is little occupation in their evaluations or their interventions; and (ii) enhancing occupational performance remains but a distant, long-term goal. When occupation is present, it is often narrowly focused on some aspect of self-care. (Fisher, 2003, p.193)

> During an eval yesterday, I asked the patient's mom what the OTs in rehab had done. She sort of looked at me and after a second, I realized

> the answer. I said 'cones, pegs, arm stuff' and in 100% honesty, the woman rolled her eyes, looked at her daughter slumped in the chair and said, 'a lot of good that did!' Chalk another one up for the cone and peg pushers! Good job!! (R. Carson, OTNow, Apr. 23, 2009)

Tension between the vision of practice described within occupational therapy education, theory and professional standards and the realities of workplace demands of some healthcare settings has created what Mattingly and Fleming (1994), in a study of the clinical reasoning of occupational therapists, described as "underground practice" or the gaps between what therapists do and what they report to others. They suggest that occupational therapists engage in these underground practices because they are caught in a "double bind" between professional values that espouse holism and a practice landscape that was, at the time of their study, and still is, largely biomedical in its approach. Mattingly and Fleming also reported that while therapists did not formally document parts of practice they were doing that were not consistent with a biomedical approach, the therapists continued to feel that those aspects of their practice were important. They describe therapists as experiencing an "unease at the heart of their practice" (p. 296). Hanson (2009) notes the continuing tendency for the hospital-based American therapists she studied to need to operate in a clandestine manner to deliver more holistic occupational therapy services – included as part of "hidden practice" was work related to psychosocial impairment; the use of and focus on occupations that were personally valued by clients in the areas

of leisure, work, education and home management; and attending to environmental considerations related to these valued occupations (p. 152).

Mattingly and Fleming's (1994) ground-breaking study was conducted in the late 1980's, and while there have been ongoing calls within the profession for occupational therapy to become more occupation-based, the challenges of occupation-based practice continue to be described by researchers and clinicians not only in North America but in other parts of the world (Alterio, 2006; Fortune, 2000: Kinn and Aas, 2009; McEneany, McEnna and Summerville, 2002; Pettican and Bryant, 2007; Wilding and Whiteford, 2007). Some of the suggested reasons for this continuing challenge are: the relative dearth of research to support occupation-based practice (Pierce, 2003; Wood, 2004), the "awkward alliance" (Friedland, 1998) between occupational therapy practice and rehabilitation, conflict between the profession's philosophical and practice base and that of biomedicine (Finlay, 2001; Rebeiro, 2000; Sumsion, 2000; Townsend, 1999), issues of courage (Law, 2004), fortitude (Perrin, 2001), limited power (Clark, 2010; Griffin, 2001) and a lack of a "firm persuasion in our work" (Wood, 2004, p. 249). Hooper and Wood (2002) have suggested that occupational therapy's philosophical roots in pragmatism are at odds with the later development of a structuralist perspective that helped the profession become more strongly aligned with medicine and less focused on the experience and value of occupation for clients. Hocking (2004) identifies two distinct philosophical threads, Romantic and rational, which appear within the occupational

therapy literature. Romantic assumptions that she identifies include stories of the healing potential of art and craftwork, the potential of creative engagement in occupation to transcend challenging circumstances, the positive impact of spending time in the natural environment and the importance of emotional expressiveness. Hocking identifies current discussion within the occupational therapy profession about creativity, the art of practice, holism and spirituality as modern echoes of the profession's Romantic ideals (Hocking, 2007, pp. 23, 35). Hocking (2008) traces rational thought in occupational therapy as a response to fitting practice to a medical rehabilitation model and to the rise of interdisciplinary team-work. She sees rationalism in occupational therapy in the ways in which occupations were analyzed for their characteristics and matched to clients' deficits, in the focus on gadgets, and the emphasis on helping clients to be independent and useful within society.

What is the impact of this continuing unease at the heart of practice? This profession, which Reilly (1962) suggested could become "one of the great ideas of 20th century medicine" and Nelson (1997) described as poised to flourish in the twenty-first century, is still not well known and struggles to attract and retain adequate numbers of practitioners to meet current and projected needs. This is true in Canada, even though the number of occupational therapists in practice has risen in Canada by 27% between 2000 and 2005 (Von Zweck, 2008). Powell, Kanny and Ciol (2008) report a vacancy rate of 8.9% in a national survey of the American occupational

therapy workforce. Riley, Whitcombe and Vincent (2008) report a 10.3% vacancy rate for occupational therapy positions in adult social services in England.

Why are there such workforce concerns? Attrition has received considerable attention in the professional literature. A 1995 Canadian study asked male occupational therapists whether they intended to continue working as occupational therapists (Brown, 1995). The results suggest that significant numbers (74% of 165 respondents) of those surveyed were considering leaving the profession within the next 10 years. A similar and more recent study done in Australia by Brown and colleagues (Meade, Brown & Trevan-Hawke, 2005) surveyed both female and male occupational therapists and found that 60% of both female and male occupational therapists indicated that they would likely leave the profession within the next ten years. Allan and Ledwick (1998) found that 19% of senior occupational therapists in a British study planned to work outside occupational therapy within the next five years. A study in Ireland found that 32% of occupational therapists surveyed were considering leaving the profession (Jenkins, 1991). A position paper on health human resources by the Canadian Association of Occupational Therapists (2011) cites research by the Canadian Institute of Health Information (CIHI)(2010) indicating that there is considerable attrition in occupational therapists in the 45 and older age group. We do not know how many of the occupational therapists *currently* working in Canada might be considering leaving the profession, but

if there is any similarity in the experiences and responses of therapists in Canada to those in other countries and if what CIHI found about the numbers of middle-aged Canadian occupational therapists leaving the field continues to be the case, there are grounds for concern.

A review of the occupational therapy literature reveals a variety of reasons that occupational therapists leave the profession. The conflicting demands of family and work life of a largely female group of practitioners, work stress (Lloyd and King, 2001), and lack of respect and/or recognition from other healthcare providers (Bailey, 1990; Brown, 1995; Moore, Cruikshank and Haas, 2006; Tryssenaar, 1999) are suggested as contributing to job dissatisfaction and attrition. Pollard and Walsh (2000) comment on how a profession like occupational therapy, which is largely female, struggles with ongoing issues of status and role definition. Wood (2004) talks about her own "heartsickness" (p. 253) as a new therapist and suggests that this came from practicing "decapitated" (p. 253) – not being aware of the ongoing scholarly discussions within the field about occupation and occupation-based practice. Hayes, Bull, Hargreaves and Shakespeare (2006) identify workplace press for generic working (asking professionals to take on new tasks/roles that may have little to do with their education) rather than recognition of/support for the use of occupational therapy skills as affecting job dissatisfaction of Australian mental health clinicians they studied. Reeves and Mann (2004) report similar concerns with press for generic working with a group of British occupational therapists, although both they and

Parkinson, Forsyth, Durose, Mason and Harris (2009) suggest that further professional development can tip the balance back towards working in a more occupation-based way. Fortune (2000) wonders if occupational therapists are not "trading occupation for spare parts" (p. 225) and abandoning occupation-based practice to become mere "gap fillers" (p. 227).

A common thread in the studies cited above seems to be concerns about professional identity, and occupational therapists' ability to enact that identity to their satisfaction in day-to-day practice within systems still dominated by a biomedical approach. In a recent study, Edwards and Dirette (2010) studied burnout in occupational therapists. They found an association between high levels of burnout and therapists feeling that they were not offering a unique and valued service. One well known occupational therapy educator and author (M. Molineux, personal communication, August 29, 2010) wonders if some occupational therapists are suffering from what Lasch (1985) calls "narcissistic survivalism", which manifests as "selective apathy, emotional disengagement from others, renunciation of the past and the future, a determination to live one day at a time…" (Lasch, 1985, p. 57). More recently Molineux (2010b), citing Giddens (1991), has suggested that occupational therapists need to address our own "ontological security" to practice more in accord with our professed values. Wood (2004) describes "heartsickness" in practice; perhaps that might align with the concept of moral distress first described in nurses by Jameton (1993). Moral distress is defined as painful emotions and accompanying physical and behavioural

signs that result from situations where an individual is unable to act according to what they know or believe to be morally right because of constraints, either external or internal. While this concept has not been extensively researched within occupational therapy practice as compared to nursing and medicine, a recent non-random online survey of American occupational therapists (Slater and Brandt, 2009) found that many of the 100 therapists who responded experienced moral distress due mostly to external factors such as limited funding, institutional policies, productivity standards that conflicted with their clinical decision-making about what they believed was required in therapy to help their clients address occupational performance issues.

How does this relate to my inquiry? In the next section I share some of my own experiences and questions from practice, my narrative beginnings.

Narrative Beginnings

Why am *I* inquiring into occupation-based practice? I hope to shine some light onto this question as I begin this dissertation. I start with a story from my practice, and then discuss some of what I've learned by unpacking the story and through completing an identity memo (Maxwell, 2005). An identity memo can be used at any point in the research process, but is often used at the beginning of the journey. This memo asks the researcher to consider their relevant previous experiences, assumptions and goals, and how these three things have shaped the choice of topic and methodology. In

this identity memo, which is not included in its entirety, I also considered the advantages and disadvantages that my goals, beliefs and experiences might have for the inquiry, through answering a set of reflective questions. These practice stories and this identity memo are part of the narrative beginnings (Clandinin and Connelly, 2000) that have led me towards the inquiry I have chosen. I will then summarize some of the discussion within the occupational therapy literature that discusses similar wonders or puzzles about occupation-based practice by occupational therapists.

Doing Occupation: A Narrative Beginning[1]

Looking inwards as I sat down to write about this, I felt tense about writing about my early experiences as an occupational therapy student. I didn't want to denigrate the work done at this facility prior to the era in which my story took place, nor did I want to deny that the work done there currently is helpful to clients. On the other hand, I did want to try to understand what it was that made it possible (for a few years) to use an occupation-based approach there – directly using real, or as close to real as possible, work tasks/routines designed to help injured workers return to work. Alongside these concerns, was the anxiety I had about looking at my personal emotional responses to that work environment. Although I know I was not alone in having found this an extremely challenging work environment, I still have regrets about things I did/didn't do, things others did/didn't do and how this environment and my then-unacknowledged depressive illness interacted. In addition, given the small practice world of occupational therapy, I know that, in spite of my not naming places or names, some elements of this story will be easy for colleagues to figure out.

To inquire using this story I will look backward and inward to my own experiences: as an undergraduate occupational therapy student; and as a manager of the therapists and therapy assistants who poured their creativity and passion for occupation-based therapy into the work we did. I will look at the landscapes in which this story lives. Working in the three dimensional inquiry space of narrative inquiry (backward/forward, personal/social and place), I will also look outwards to consider the social contexts in which this story lives: exploring what it was like to operate within a large, highly political

[1] Note: Portions of the text that are taken from an extended identity memo are in italics. Practice stories are in plain text, indented and fully justified.

bureaucracy; and to be a female department manager in a male-dominated environment. This inquiry will also necessarily explore the stories that the occupational therapy profession tells about itself, particularly about the value of practicing in ways that are true to the core values of occupational therapy, and how to flourish in professional practice landscapes that may be indifferent to, or even hostile towards, occupation-based approaches.

A tale of rubber chickens, house-building, green gym shorts and work boots

The story starts in the mid-1970's when I did a practicum at a rehabilitation centre in my home city. The centre was well respected, one of the first of its kind in the country and offered services not found anywhere else. It was one of the largest employers of occupational therapists in the province. I showed up for practicum wearing my peach-coloured polyester uniform, wondering what it would be like to work with so many men, making things as therapy in the industrial workshops that were completely new to me. What did I know about carpentry or plumbing or…? My first day was not a good one - I listened to two supervising therapists, sitting within earshot of my classmate and I, complaining about how much work it was to have students. I debated all day about what to do about this, and ultimately went to talk with the therapist responsible for coordinating student placements. She agreed that this wasn't very professional on the part of the therapists and promised to talk with them. Great – Day One and I had already made trouble!

In the following days, I learned about the therapy programmes in place for injured workers. In essence, workers completed a circuit of activities within the different rooms in the centre. There was a woodworking room, a therapy pool, a gym, and a weaving and handcrafts area, along with other specialized services. I saw men wearing baggy green gym shorts and steel-toed boots sitting weaving at large floor looms, or making baskets, or building wooden toys. I realized what the source of the ornate wooden address markers I'd seen around town was – they were a favorite therapy project at the centre. I met some truly inspired therapists, very dedicated to their work, and some I arrogantly labeled as "lifers", not that easily distinguished from some of the injured workers; both groups seemed to be going through the motions with very little enthusiasm. While each worker had an individualized programme, the activities offered within that programme seemed to reflect what the therapists thought would best affect physical recovery, and what was easily available within the centre. It seemed that there was little that linked the therapeutic activities done by any injured worker to the complex demands of their specific job. Overall, I came away from the experience wondering how/if the activities used in therapy motivated injured workers to participate in therapy, and if

what they were doing there gave them any real sense of how they would do when they returned to work. Little did I suspect that I would return to this place.

This story now jumps forward to 1990. After completing graduate studies in occupational therapy, I re-entered the same sprawling brick building I'd left more than a decade earlier as a student. This time I was managing a department that had recently been formed from the amalgamation of two other departments. The forced marriage was traumatic for many involved, with people resigning, taking stress leave and a sense from the "front line" therapists and therapy assistants that management did not value the work they did. The directors of the facility had decided to pursue accreditation from an international accrediting body, and made radical program and administrative changes throughout the centre to implement a treatment approach called "work hardening". I'd been hired to manage one of the major programs. While I was philosophically in agreement with the new approach because I could see occupational therapy written all over it, it was clear I was walking into a situation where people were adjusting to changes they hadn't themselves initiated.

The first few weeks I felt like Gretel in the old fairy tale, leaving crumbs behind me as I re-acquainted myself with the turns and twists of the buildings, and met the many staff members I supervised. It was early summer, and my primary concern was making sure I could cover the bases for each team, given the number of staff taking summer vacations. Slowly, I started to get to know the therapists and therapy assistants, my assistant managers and the other staff - particularly the psychologists, case managers and admissions coordinators. I did everything I could think of doing as a manager and as an occupational therapist to start developing a sense within the department of collegiality, of excitement for the work we were doing and its positive impact on clients, and of pride in our creativity and connectedness with clients. I also made a few key hiring decisions that brought some newly graduated therapists and a new assistant manager into the department.

It was a tough slog. The first few staff meetings were pretty tense – I remember a lot of staff sitting with their arms crossed in what I read as a "prove it to me" stance. Still, there was enough residual goodwill between older staff, energy from some new staff and a commitment to the clients, to take us through the summer. And there was a building sense of excitement as we started to design and set up environments which simulated specific work environments and tasks – accurately weighted pushcarts and inclined ramps for flight attendants: a small two-story house for the construction trades workers; a "ward" environment with hospital beds, wheelchairs, lifts and other equipment for nurses; a sorting station for the letter-sorters; weighted rubber chickens for a chicken-picker (who even knew there was such a job as chicken picker?). Some of the clients were as excited as we were, and

were front and center in helping with design and construction – demonstrating their expertise in their fields. Some employers loaned or gave us equipment to increase the realism of the work tasks we were trying to provide. Therapists visited worksites so they could have a greater understanding of the work environment.

The accreditation visit went well, and we became the first accredited work hardening programme in the country. I started to be able to sleep at night. Going to work was exciting. What would the teams be up to next? How would they engage the clients in occupation (or "real simulated" occupation that contains within it enough of the essence of the work to feel real to the client), help them recover physically from their injuries and also regain confidence that they can *do* and *be* again? One of the staff brought in a CD player and a copy of Queen's *We Are The Champions.* The music and an espresso machine went into the small library we'd set up that contained relevant books and articles for the therapists. This tune became our departmental song, and was played most mornings before we started work. We were rockin'. Ah, hubris …

We had a great two years of working this way. We were asked to, and succeeded in, significantly increasing the number of clients we were working with. It was challenging but do-able. The clients seemed much happier with this new approach (which occupational therapists would tell you is really not new, but in some ways harkens back to the start of the profession). Workers commented that we were really trying to understand them and their jobs. Staff seemed to be excited to be able to use all of their creative and technical skills. Some of our new graduates proposed and started a pilot study looking at outcomes. In spite of the challenges of working in a large corporation with conflicting priorities and often brutal internal politics, the therapists, technicians and therapy assistants told me they were proud of the work they were doing. I was proud too.

But the writing was on the wall. The organization has a history of swinging between attending more to injured workers' needs or to employers' needs. We didn't have the kind of evidence yet (in spite of a small-scale research project) to show conclusively that this approach worked better than the traditional exercise and (often) non-job related activities used in the past. And to work this way seemed like it might be more costly than generic rehabilitation approaches; that could boost costs to employers.

The pendulum was swinging. Plus, we'd been cocky. What had so proudly been built was about to be torn down. The director and senior management team started making noises about whether we couldn't get equally good results from a more generic approach. The accrediting body produced standards for clinic-based work conditioning programs, what I called "work hardening lite", in part as a response to concerns from other rehabilitation professions who didn't have the skills or

> resources to be able to offer a full work hardening programme. This opened the doors for injured workers to attend programmes closer to home – a good thing for workers. It also opened the door to the suggestion that work hardening was a bit of a luxury. What had only months before been something the organization bragged about was becoming something they no longer wanted to do.
>
> I wish I could say I found a way to prevent that change from happening. I didn't. My physical and mental health deteriorated in the face of the moral distress I felt as I saw my staff respond to the coming changes. A few key staff members, like the proverbial canaries in this particular mine shaft, left or became ill. I too left and ran, moving south to the United States to work at a small clinic where the therapeutic approach was less occupation-based, but the administration was more supportive of what we were doing and open to moving to a more occupation-based approach. I felt like a failure as an occupational therapist.

Unpacking this story: identity within a three dimensional inquiry space

What made it possible to practice in a more occupation-based manner during the time this story was lived? This is not a triumphal story – but one that holds within it representations of both the pragmatist and structuralist voices that Hooper and Wood (2002) identify as the two dominant discourses that have shaped occupational therapy practice.

This narrative of practice, like the stories my participants shared, carries within itself echoes from other stories of my practice as an occupational therapist, connected like links in a bracelet or scenes in a movie, or perhaps, if I look inward and outward, in addition to forward and backward, like the layers of an onion or the coils of a basket. This story is also located in a place and travels across time. It is nested in larger changes within healthcare and rehabilitation, and within occupational therapy practice itself. Within this story are my "stories to live by" (Connelly and Clandinin, 1999) that are linked to my choosing occupational therapy as a

career, to experiences as a student in both the classroom and the clinical environment, to the choices I've made about my practice, my current work as an occupational therapy educator, my choice to integrate art into my practice and my interest in the particular research endeavour described in this dissertation.

In narrative inquiry, researchers inquire into temporality (past, present and future), sociality (the personal and the social) and the impact of place. This three dimensional inquiry into narratives will be used to briefly discuss the narrative beginnings (practice stories and an identity memo) I undertook in my initial framing of this inquiry. In the three-dimensional inquiry space where I am inquiring into my narrative beginnings, I look backward and forward (temporality), as well as inward – to the personal "feelings, hopes, desires, aesthetic reactions, and moral dispositions" (Connelly & Clandinin, 2006, p. 480) and briefly outward to the social – to the "surrounding forces and factors, people and otherwise" (Clandinin, Pushor & Orr, 2007) (sociality). The third dimension of this three dimensional inquiry space (place) considers experiences within specific places and environments.

In working with this story, I have used an identity memo to explore my experience within the three dimensional inquiry space (Clandinin and Connelly, 2000) – to examine the stories to live by that I brought into my career in OT, my initial education as an occupational therapist (including the clinical education story nested in this story), my previous experiences as an

occupational therapist, my graduate education and my current practice.

What did I learn? What was educative/mis-educative?

From my identity memo: Entering occupational therapy studies

I stumbled into occupational therapy not knowing much about it, other than having the sense that it was a health profession that had room for my interests in music, art and craft. One of my stories to live by is that we are here to serve others. My parents raised my sister, brother and I with an understanding that service to others is important, either through one's work, or through involvement in the community. I wanted to do something that was helpful and considered healthcare or education after an early interest in political science. We had a neighbour from India who worked as an occupational therapist, but other than that I'd never met an occupational therapist prior to applying for admission to the programme. I had spent most of my high school years deeply involved in music and had considered music therapy training, but this course of studies was not offered in my hometown.

So I entered the occupational therapy programme, after completing a degree in History and English, not really knowing what the discipline was, but with a notion that it used art and craft as therapeutic tools for working with what we would have then called patients. I was interested in the artistic aspect, and also intrigued to learn more about the human body and mind.

I remember reading a definition early in the first year of my programme that described occupational therapy as "the art and science of directing man's participation in selected tasks" (American Occupational Therapy Association, 1972). The "selected tasks" I heard about and saw in my practica included crafts, simulated or real work tasks, games and sports, cooking and other domestic activities. I was pleased to be entering a profession that was both an art and a science. It made sense to me that this work would need to be both artful and scientific. I had resisted seeing science as the be all and end all growing up, even though my father was a scientist. But even early on I could see that he used as sources of knowledge not only what he could see, feel, touch and measure, but also hunches, intuitions and ideas that woke him up from his sleep, knowledge gained from time spent in the field, looking at rocks, walking though all kinds of terrain at home and around the world, tramping up creek beds, staring into campfires and thinking about what could have happened those billions of years ago. This is how I learned about the art and science of inquiry. Up until his death at age 85, he still practiced that way, collaborating with other scientists with advanced technical analytical equipment or skills he did not have who were able to explore his ideas using those tools. I saw him working as both a scientist and an artist in untangling the questions of how and when the North American continent was formed; how the land underneath our feet came into being.

The first year in the occupational therapy programme was a challenge – 6+ courses each semester, lots of information to memorize, large science classes with instructors who were difficult to understand. The biggest challenge of all was that I wasn't enjoying my yearlong "therapeutic media" class – a course on using art and craft activities as therapy. Even though I had always been involved in artistic and creative pursuits, I was not at all happy with this course. Part of this was my response to the instructor. His announcement on the first day of class that it was "a waste of money training you girls, as you'll all just marry, have babies and leave the profession" outraged me. Given this, I wasn't able to enjoy this class for its own merits. In addition to my annoyance at the instructor, I was also wondering if some of the particular media we were learning to use were relevant to contemporary practice. I think at one level, I was also somewhat embarrassed that we weren't using something more "scientific" and sophisticated than art and craft media. I was already learning to "despise the fluffy bunny" (Perrin, 2001). I took the old-fashioned attitudes of the instructor as applying to what he was teaching and, I think, threw away the proverbial baby with the bathwater. From that point on, I became much more interested in work tasks in therapy, which had at least some sort of aura of scientific respectability to them.

I did a practicum where occupational therapists used a variety of art, craft and recreational activities prescribed to help injured workers achieve specific physical and/or psychosocial goals but very often not something that the individual would have chosen as a therapeutic endeavour. When I saw men in steel-toed boots and green gym shorts weaving with a floor loom, for instance, I could see that this activity had the potential to help someone meet a multitude of physical goals. Nevertheless it made me cringe to see an injured construction worker who clearly didn't want to be weaving, metaphorically shackled to his loom. The centre did offer clients some activities that fit their needs and interests better simply by being something appealing. So, for instance, in the winter there was an outdoor curling rink and there were woodshops and small appliance repair areas, etc. where clients could work on projects they had chosen.

As I look backward, this negative experience as a student with using activities as therapy was balanced out with other more positive events. I was fortunate enough to have had practica experiences where I saw art/craft and other activities being used by skilled occupational therapists, both in assessment and in treatment. I saw how art helped clients express what had been beyond words, and discover things about themselves and others that had been hidden from their conscious awareness. I noticed that individuals who otherwise seemed unable to concentrate during verbal groups became engrossed when working on real life projects. I worked with a young mother making meals in the occupational therapy kitchen so she could feel confident that she would be able to return to safely cooking for her family. Working with a young woman in a cancer care unit, I saw how being engaged with the project she'd chosen distracted her from spending all day (mostly alone)

thinking about dying, and gave her the opportunity to make something that would provide a memento for her parents.

From my identity memo: Starting practice as an OT

When I graduated as an occupational therapist, I first worked in a group psychotherapy programme. While the programme's theoretical underpinning certainly would have lent itself to using artistic media or other active "doing" in therapy, the focus was very much on talking - exploring distant relationships and issues through current relationships and issues within the group and between group members and therapists. I remember being quite offended when one of my professors asked me when I was going to practice "real OT"? Looking back, it was a good question.

My next job brought me back into the occupation-based world that I had discovered as a student. I was hired as a senior therapist in a hospital that had both in and outpatient psychiatry programmes, including an inpatient unit for adolescents. Not long after I started there, the occupational therapists and recreation therapists working in psychiatry moved into a new, custom-built space, with a big kitchen, a pottery room, a large art/craft area, a greenhouse and several multi-purpose group activity rooms. While I had some input into the design of this area, it was the support of the Chief Occupational Therapist, who had been educated in England and thus was well versed in the use of occupation-as-means, which ensured that this space was developed. There was, again, both the expectation of and the resources for, occupational and recreation therapists to engage clients in "doing" that which was appealing, connected to real-life and linked to the clients' goals.

While most of our patients were very willing to participate in occupational therapy activities, the strongest response came from the adolescents – perhaps because they were still at a stage in life where they were involved in art activities in school and interested in music, video and other popular culture occupations that we offered, as well as in learning skills for independent living. Clients created wonderful clay and paper art, planned and cooked meals, potted and cared for plants in the greenhouse, produced a talent show, made movies, and participated in games and recreational activities. We hired an artist as a therapy assistant. She shared her own experiences with art as therapy, as well as her expertise in ceramics and sculpture. The occupational therapists there also developed work experience positions within the institution, so clients who wanted to enter or re-enter the work world could try working within a supported environment.

After that, I moved to another city and returned to working in a programme that was largely talk oriented. From there I went to a smaller hospital where I was the only occupational therapist working in psychiatry. In this setting, I had some opportunities to use an occupation-based approach within my work. The psychiatry service was headed by a psychologist and was a training centre for systemic therapy, and later narrative therapy. The high-

status work was being done in talk therapy, but there was some understanding of the value of doing, both for assessment purposes and as intervention.

This was most evident in the "Medication Clinic" run by an inter-disciplinary team. Once a week, clients would come for a late afternoon appointment with their psychiatrist or nurse, then stay for a communally planned and prepared dinner, then an education session or sports or games. For some clients, even though they were living in the community, this was one of their few opportunities for social interaction and for fun. As an occupational therapist, I was pleased to see people gain communication skills as we cooked together, become more active and confident in the games and sports we played, and be able to concentrate on what guest speakers were saying. We also heard from clients about what they were doing in the community, such as going to a movie with a group member or taking on a part-time job. While the doctors expressed their happiness about participants' increased medication compliance, as an OT I celebrated these achievements as signs that our clients, many of whom had a long history of mental illness, were finding ways to re-integrate into the community and re-engage in valued occupations. I doubt I put it in those words. The medication clinic was what I felt saddest to leave when I decided to start graduate studies.

From my identity memo: Graduate studies

I truly can't pinpoint why I returned to university to do a master's degree in occupational therapy. Certainly there was no real push at that point for graduate level education for occupational therapists. The graduate programme had just started. I knew there were some new faculty members who might help me learn more about the how and why of occupational therapy – this profession I so loved but felt I couldn't adequately explain to others.

I was lucky. We had small classes and time for deep conversation about occupational therapy theory and practice. We were introduced to some new ways of exploring questions. One faculty member, Laura Krefting, was amongst the first occupational therapy researchers to suggest the value of qualitative approaches for exploring some issues in occupational therapy practice. I was also fortunate to take a class from Jan Morse, one of the pioneers of qualitative research in nursing. I was excited about what I might learn about practice through using different methods of inquiry.

From my identity memo: Back to the clinic

After I completed my master's degree, I returned to work as an occupational therapy manager in the same return-to-work programme for injured workers where I'd been a student more than a decade earlier and which I have discussed in the practice story earlier in this chapter. Therapy teams were organized around occupational groupings rather than injured body parts. The organization had started using an approach called "work hardening" to

improve their success in helping injured workers return to employment. Work hardening uses real or simulated work activities in combination with exercise to enhance the ability of an individual to meet the demands of their work.

My team of therapists and technical instructors worked incredibly hard, using their creativity to make work tasks as real as possible. "Real simulation" was linked to individual return-to-work goals and designed so the client could see that their ability to complete specific work tasks during therapy meant that they were likely to be able to do these tasks safely and competently when they returned to work.

Nelson and his colleagues (Beauregard, Thomas and Nelson, 1998; DeKuiper, Nelson and White, 1993; Hall and Nelson, 1998; Hartman, Miller and Nelson, 2000) have explored the impact of using real materials and tasks versus rote exercise and imagined tasks and shown that there are differences in movement patterns, memory and perseverance. I saw some of those differences in the work hardening programme. Fisher (1998) talks about evaluating the characteristics of therapy activities along four continua: ecological relevance, source of purpose, source of meaning, and focus of intervention. She suggests that too many therapists are using exercises (simple or with added purpose), or occupation that is contrived and driven by the therapist's goals for the client. She proposes that occupational therapists should focus their efforts on using therapeutic occupation (which I take as being similar to occupation as means), which she defines as therapy activities which relate to the client's purpose and meaning, actively involve the client, and are as close as possible to being "real" – using real objects within the natural environment. These therapeutic occupations may be graded to become more challenging as the client progresses. Or they may be designed to directly intervene with impairments within the context of occupation. The other set of therapy activities that she sees as being squarely within occupational therapy's mandate is adaptive or compensatory occupation – helping clients to return to previous occupations through the use of adaptive strategies or equipment. I think that what we were trying to do in the work hardening programme came close to being therapeutic occupation. The activities we designed were transformed from being mere exercise or contrived occupation to being therapeutic occupation through the collaboration between therapist, technician, therapy assistant, employer and worker.

Price and Miner (2007) suggest that generic activities/exercise can become occupations through a process of co-creation between client and therapist during the process of therapy. Both clients and therapists were actively co-designing therapy through occupation. I saw that every day at the rehabilitation centre.

I moved on from that setting to a small clinic that also provided therapy to injured workers, but without space, resources and expertise to do much more than work-related exercise. It was difficult to simulate individual workers' work tasks and conditions. Occasionally we'd have a referral for an injured railroad worker. We had equipment given us by the railroad so we could see if the worker could meet some of his/her work demands and a small warehouse

where we could check people for physical readiness to return to warehouse work. One big issue was keeping clients motivated while doing repetitive work tasks that did not specifically relate to their own job tasks or work conditions. The organization had made a commitment to move towards "real work hardening" and did finally achieve this.

Looking inward to reflect on all of these clinical experiences, I can see that I was taken by what Hocking (2007, p. 36) describes as the Romantic ideals of occupational therapy:

> *Therapists relegated their Romantic beliefs about clients to the realms of 'underground practice'. That is, they maintained a façade of rational explanations to account for what they do, why they do it, and what might be achieved while yearning for practice the way it 'should' be. This was not a longing for the crafts of old, or not necessarily. It was a sense that there should be more to practice than bath boards and shower assessments, work simplification and skills training; that there ought to be a place for acknowledging the trials and heart-breakings of disability, along with the triumph of recreating a life.*

This was part of my longing too, this longing for practice as it should be, but it is only now as I unpack this story that I have words for what I was feeling. I was learning just how difficult it could be to be an occupation-based *occupational* therapist. It was, and has continued to be, somewhat easier for me to be occupation-based when working in mental health. Perhaps the pragmatic discourse (Hooper and Wood, 2002) and the Romantic ideals of practice were, and still are, more dominant in mental health as compared to the structuralist discourse and rationalist approach of some physical rehabilitation settings.

Working in the three-dimensional inquiry space, I look forward – how does what I learned in the living of this story affect me now and influence my future possibilities as an OT educator/researcher? Shortly after I left the work rehabilitation facility to escape the pain of practicing in ways that were no longer aligned with my values and beliefs, I had the opportunity to start

teaching in an occupational therapy academic programme. As I think about this within my identity memo, it is clear that the experiences described in my story of "real simulated" work still inform and trouble my practice as an occupational therapy educator.

From my identity memo: What do I tell students about occupation-based practice?

I've now been teaching at universities in Canada and the United States for longer than I was in clinical practice. During my career as an occupational therapy educator, I've taught a variety of courses, including occupational therapy theory, work rehabilitation and ergonomics, mental health, community development, assessment, clinical reasoning, creative and expressive media, group work and therapeutic use of self. One constant theme running through my teaching has been a discussion of the importance of occupation as means and occupation as end. There is considerable agreement within the professional literature that the ends of our work as occupational therapists are related to helping clients engage in their chosen occupations. The other aspect of occupation-based practice is use of occupation as means, using meaningful and real activities as therapy. I think it does require a certain perseverative persistence to suggest that occupational therapy is most powerful when it involves the use of occupation as means. While there is some evidence of the therapeutic power of occupation both from within the profession and from other health researchers, and even though the profession has become considerably more sophisticated in developing theory to explain the influence of occupation on health, we cannot, as a profession, claim to have incontrovertible evidence to support our claims about occupation as means.

Some of what I do and teach as an occupational therapist I take on faith. If, as Kelly and McFarlane (2007) say, occupational therapy is a culture and a cult, I have been a faithful acolyte at times – lighting the flames on the altar of belief in the power of occupation, particularly occupation as means. I have also tried to maintain a certain wakefulness to other interpretations – exploring alternative views of the practice of occupational therapy. Hammell (2009) speaks of the need to critically examine our "sacred texts", particularly in relation to occupational therapists' assumptions around productivity and leisure occupations, how we classify occupation and the presumed positive impact of occupations on health. Iwama (2006) has reminded the profession that many of our core ideas, including concepts around occupation, come from a Western perspective. Hooper (2008) calls on us to examine our assumptions about human experience, about the body, about how knowledge is gained, about core OT knowledge, and about the future of our clients, the profession, and ourselves.

Why believe, why share these ideas and ideals with students – if the published evidence for the impact of occupation on health is still somewhat sparse within our own professional literature (Creek and Hughes, 2008; Hammell, 2009; Law, Steinwender and Leclair, 1998; Molineux, 2010a; Rebeiro, 1998) and evidence for the use of occupations as means in occupational therapy ever scarcer (Brooks, 2006; Perruzza and Kinsella, 2010; Price, 2003)? Turner (2007) would argue that we do know about the effect of occupation on health but that most of that knowing is linked to intuition, tacit knowledge, philosophy and indigenous wisdom rather than to the outcomes of randomized controlled trials. Kinsella and Whiteford (2009) argue that occupational therapy's practice knowledge should take into account not only traditional research evidence, but multiple ways of knowing and therapist judgment (p. 255). Reagon, Bellin and Boniface (2008) suggest that occupational therapists find evidence for practice not just within published research, but also in their own and experts' clinical experiences, clients' self-reports, specialist groups – in all, a wide variety of external and internal sources of evidence. And, I am convinced, through stories – told and inquired into by clinicians and clients.

Why believe? Because we are starting to have evidence derived from research paradigms that better allow researchers to explore the lived experience of doing and its impact on health. Because, like Molineux (2001), I keep my eyes open to research evidence about occupation within the professional literature of a variety of healthcare professions. Because I have my own evidence from practice - I've seen occupation-based practice succeed as a therapist working with adolescents and adults. Because I've heard success stories from other occupational therapists about their own practices. Because I've experienced the power of occupation as means in my own life when I was grappling with a particularly lengthy visit by the black dog of depression. Because I see and hear stories from people coping with health issues through occupation, for example Lydon's (1997) "The Knitting Sutra: Craft as a Spiritual Practice". More often than not, these are not stories in which occupational therapists appear in any role. When occupational therapists do appear, it is sometimes cringe inducing: for instance, Bonnie Sherr Klein's (1998) story of having to sneak time to work on her film (which she saw as a priority and could easily have been understood as her occupational therapy) around the activities the occupational therapists she worked with prescribed for her.

I suspect that I'm not the only OT that keeps a clipping pile of newspaper and magazine articles, and that bookmarks blogs and web-sites that speak to the power of specific occupations to influence health. And while my OT radar is most attuned to creative/expressive occupations, I do also notice when there is something about sports or baking or yoga or being outside in nature, or having dinner as a family or any other of a myriad of occupations that we are discovering can affect health. I would say that I have used many of the same strategies to gather evidence for my practice that Reagon et al. (2008) found in their research with occupational therapists in England.

In the three-dimensional inquiry space where I've made my narrative beginnings through telling a practice story and completing an identity memo, I've looked backward and forward; inward – to "feelings, hopes, desires, aesthetic reactions, and moral dispositions" (Connelly & Clandinin, 2006, p. 480) and briefly outward to the social – to the "surrounding forces and factors, people and otherwise" (Clandinin, Pushor & Orr, 2007, p. 23). The third dimension of this three dimensional inquiry, place, considers experiences within specific places and environments. The narratives in this chapter occurred in specific clinical environments. As I think about place, I recognize that, for instance, having room to build a house inside a rehabilitation centre opened possibilities for occupation-based practice, as did having custom-built therapy environments in one of my other occupational therapy clinical jobs. At the rehabilitation centre, having an office located right next to the doorway joining two buildings allowed me to have a sense of the comings and goings of therapists, clients and administrators. A candy jar on a bookshelf right inside my office door created an excuse for some people within the centre to pop in to grab a treat as they went by and share with me some of what they were doing. The small departmental library with occupational therapy books/journals and an espresso machine provided a place for therapists to take time to read articles and talk with others about their practice. The broom closet that became my office in another setting influenced my practice too, as did sharing a therapy place with the physical disabilities occupational therapists.

Katherine's story at the beginning of this chapter about asking a client to make coffee also shows the impact of place – she had room in her office to have a small area where a client *could* make coffee. My places within academic environments have provided me with opportunities for inquiring into occupation-based practice through discussion in classrooms, office and hallways with colleagues and students, as well as easy access to the professional literature and to conference spaces (whether face-to-face or of a virtual nature). Being in academic places has sometimes separated me from where occupational therapists engage in clinical practice, although I have had the good fortune to be able to supervise students doing practica in a variety of community agencies, I have been active within the mental health occupational therapy community of practice, and I have been a member of a national committee that includes both clinicians and academics, so I have not been entirely cut off from the world of therapists and clients.

Research puzzles

Narrative inquirers typically do not frame their inquiries as *questions* to *answer* but rather as *puzzles* to be *explored*. Given the issues and context described previously, and my own experiences and wonders, I was interested in working in community with occupational therapists to explore stories about occupation-based practice. With an enduring focus in the profession on "occupation as means" and "occupation as ends" in practice (Crabtree, 1998; Hocking, 2007; Pierce, 2003; Wilding & Whiteford, 2007, 2008), it seems

important to explore narratives from therapists who have tried to practice in this way. As I inquired narratively within and across these practice stories, what did I learn about the stories to live by that brought these therapists into the profession and that sustain them in their practice? What did I learn about participants' professional education and how that continues to influence their practices? What can they share about their experiences of bumping up against, conforming to, or resisting the dominant story of biomedicine? What happens within the varied places in which occupational therapy occurs?

I wonder if, in sharing these stories, it might be possible to start some narrative repair of occupational therapy identity? Nelson (2001) describes the possibilities of narrative repair of damaged identities, and suggests that this can be achieved through developing counter-stories. She tells a story of how counter-stories might come into being, through narratives shared within a chosen community. She proposes that this narrative repair of identity allows members of the community to exercise moral agency. She suggests that the counter-stories told within communities of choice can act as powerful way of developing the ability for "resistance and insubordination" (Nelson, 1995, p. 24) to the dominant stories of the larger community. I wonder if sharing stories of occupation-based practice might encourage the occupational therapists in this study and perhaps others reading the publications that come from it to consider new possibilities, through providing a moral space for exploring identity and agency within our practices?

I am not alone in having these wonders. A recent study used participatory action research with a group of Australian occupational therapists (Wilding & Whiteford, 2007, 2008, 2009) to explore challenges in occupation therapy practice. They report that occupational therapists found considerable challenges in working from an occupation-based perspective within an acute care hospital. They also found that the co-researchers were able to effect changes in their work through engaging in reflection within a supportive community of practice (p. 185). Perhaps they created a moral space for their practice?

Mattingly and Fleming's (1994) work on clinical reasoning and Mattingly's (1998) exploration of healing dramas focused on occupational therapists as well as clients, using an ethnographic approach to explore what happens in therapy. While these studies were not intended specifically as explorations of occupation-based practice, they did introduce the concept of "underground practices." What underground practices did this inquiry excavate?

Following from Mattingly's work, Price (2003) examined two therapists engaging in occupation-centred practice in two quite different pediatric settings – a neonatal intensive care unit and a community-based private practice. These two therapists were nominated by their peers as being occupation-centred. Price observed the therapists, children/infants and parents during therapy, and interviewed therapists and parents about their experiences within occupational therapy sessions. This study used narrative

analysis and micro-analytic strategies (Mattingly, 1998) to examine the process of occupational therapy with these therapists, children/infants and parents. Price reports that these occupation-centred therapists saw social interaction and participation as the most important outcomes of their work. She suggests that activities became occupations through a co-creative process of defining what therapy experiences meant for who the child/family was/were becoming (p. xi). I wondered if/how participants in the study might tell stories of activities becoming occupations? Or might these be considered co-occupations that emerge?

Ward, Mitchell and Price (2007) interviewed three individuals with spinal cord injuries who had been clients of two therapists identified as being particularly occupation-based by their peers. The researchers describe using narrative analysis (p. 151) to analyze participant's stories. Participants identified seven occupation-based approaches experienced during their occupational therapy: participation in occupation, removing occupational performance barriers, problem-solving, occupational story-making, occupation as means, attention to intactness and enabling social participation (p. 154). Two of these – participation in occupation and occupation as means – are of particular interest within the context of this inquiry. I wonder what the researchers would have heard in talking with these therapists about their stories of practice with these particular clients? Might they have experienced what Butler, Kay and Titchen, cited in Wilding (2010) did – that as therapists became more experienced they were less able

to articulate decision-making processes within their practice? Could that have been a factor in this inquiry? Could/how could narrative inquiry contribute to a greater understanding of these moments in practice and help therapists better articulate what was/is happening from their perspective?

Brooks (2006) used a phenomenological approach with five occupational therapists working in a rehabilitation hospital to explore how therapists were integrating occupation into their practices. In exploring external and internal factors relevant to practicing with an occupation-based focus, supportive leadership and the importance of therapists using narrative reasoning rather than simply following treatment protocols were noted as being critical. I wondered what I might find looking both at the personal and social in the stories of my participants? What would I hear about the landscapes within which participants live their practice stories?

In a critical participatory action research project, Nicholson (2012) explored becoming an "occupation specialist" with a community of occupational therapists in New Zealand/Aotearoa. During the phases of the project, occupational therapists reflected on contextual and historical influences and barriers to occupation-based practice, immersed themselves in occupation, and started to use occupation-in-action. Nicholson (2012) emphasizes the importance of professional community, and recognition that the context of practice both presses and affords occupation-based practices. She talks about the importance of reflection, reading and critiquing the professional literature in community, and the value of dialogue in community,

of finding a place to explore and reconstruct practice, and of recognizing the balance between paradigms and practice. Recognition of the core value of being client-centred is another key finding, as is the critical nature of using and sharing occupational language to exemplify a meaningful practice.

Summary

In this chapter I have set my inquiry into context, through describing the multiple meanings of the terms I am using, briefly describing the history of my profession and discussing my own experiences using excerpts from an identity memo. I have briefly introduced a core undertaking of narrative inquirers – use of a three-dimensional inquiry space to look backward/forward, inward/outward and to the impact of place through discussing my story with these three dimensions in view. I have described some of the experiences that led me to this inquiry, and my wonders about occupation-based practice, about therapists' *stories to live by*, wonders about how the social context contributes to shaping practice, and whether sharing stories of practice might create a moral space for exploring identity and agency within our practice. I have reviewed and summarized related research. Finally, I have, I hope, provided some sense of why this inquiry is important for occupational therapy practice. I move now to further describe narrative inquiry methodology, and how this methodology was used in this exploration of occupation-based practice.

Chapter Two: Narrative inquiry methodology and its use in this practice inquiry

Introduction

This chapter introduces narrative inquiry methodology, starting with a brief review of the development of the methodology. The "turn to the narrative" in occupational therapy/occupation science is also briefly reviewed. Narrative inquiry is described, and the design decisions that narrative inquirers detailed to further illustrate the methodology. This discussion of design decisions incorporates further discussion of narrative research in occupational therapy.

Narrative inquiry: historical roots

Narrative approaches to inquiry are not new. Indeed, as Clandinin and Rosiek (in Clandinin, 2007) note, while the term *narrative inquiry* is relatively recent, there is a long tradition of *narratology* in the humanities, and more recently in life history and life story work. Both Connelly and Clandinin (1990), and Pinnegar and Daynes (2007) examined the roots of narrative inquiry. They tell the story of how narrative inquiry methodology has been developed over the thirty-plus years that Clandinin and Connelly have been working with their associates to develop and refine a methodology

designed as a means of exploring experience as a narrative composition. Most of this research to date has taken place within education, although there are now a number of narrative inquiry studies that use this methodology to examine concerns within nursing and medicine (Barton, 2004; Caine, 2002; Cave & Clandinin, 2008; Clandinin, Cave and Cave, 2011; Estefan, 2008). Reissman and Quinney (2005) examine the use of narrative in social work. Reissman and Speedy (2007) look at the use of narrative in the psychotherapy professions, including social work, counselling and psychotherapy. Mattingly (2007) writes of her narrative research into occupational therapists' practice.

A 1990 article by Connelly and Clandinin in *Educational Researcher* provides a helpful introduction to narrative inquiry and marks the first time they named the methodology they had been developing as narrative inquiry. They describe what narrative inquiry is, the forms it may take, criteria that might be used in evaluating these inquiries, methods, and the ways this research can be presented as inquirers write up their work. The article further reviews some of the risks and challenges that might arise from narrative inquiries. Connelly and Clandinin (1990) describe narrative inquiry as "the study of ways humans experience the world" (p. 2) as they lead storied lives, individually and socially. They comment that it is both *inquiry into narrative* and *narrative inquiry*; narrative being both the phenomenon studied, that is, a narrative view of experience, *and* the method used for the study of experience as understood narratively. The contribution of John

Dewey's work on the nature of experience to the development of narrative inquiry is noted both in this article and in subsequent descriptions of the methodology (for instance, Clandinin and Connelly, 2000; Clandinin and Rosiek, 2007). Connelly and Clandinin (1990) further explore narrative inquiry alongside the ways narrative is conceptualized in other disciplines. They cite Mitchell's (1981) *On Narrative,* which they describe as providing a review of narratology across a wide array of fields including history, philosophy, art, theology and others. They note the parallels between narrative in educational research and in social science research more broadly. For instance, they discuss Polkinghorne's (1988) examination of narrative-related research in "individual psychology" from the mid-1800's, including a number of approaches with which contemporary occupational therapists would be familiar, for example, case histories, life span development, and Freudian psychoanalysis. They examine narrative research as used in sociology to examine groups and communities. They present Eisner's (1988) view that aligns educational research focused on experience with other qualitative research in education in experiential philosophy, psychology, critical theory, curriculum studies and anthropology (Connelly and Clandinin, 1990, p. 3). Dorson's (1976) work on oral history as found in a variety of forms (material culture, customs, arts, epics, ballads, myths and others) is also reviewed and the value of these forms in narrative work in educational research noted. Finally, they highlight Elbaz's (1988) discussion

of the close links between narrative and feminist studies, with their mutual interest in *voice*.

Clandinin and Connelly (2000) further describe the history of narrative inquiry methodology through discussing other researchers in the social sciences and in medicine that have influenced their thinking as they and their colleagues have developed narrative inquiry methodology. Drawing on Dewey's conception of the nature of experience and particularly his two criteria of experience, interaction and continuity, they note that the idea that all experience is both personal and social, and continuous, is the key contribution of Dewey's thoughts to their development of narrative inquiry. Clandinin and Connelly (2000) note the contribution of Johnson (1987) and of Lakoff and Johnson's (1980) work on embodied metaphor to their thinking about narrative inquiry. MacIntyre's (1981) discussion of *narrative unity* is also identified as influencing their work. Anthropologist Clifford Geertz's (1995) career retrospective looking back on four decades in the field of anthropology, suggests to Clandinin and Connelly (2000, p. 6 – 7) the importance of acknowledging constant change in both the researched and the researcher, and need for narratives that include the narrator. Another anthropologist, Mary Catherine Bateson, is also identified as having offered insights that have been incorporated into Clandinin and Connelly's thinking. One of Bateson's (1994, 2001, 2011) key interests is in learning, in how continuity is maintained in times of change, of the importance of improvisation, and how individuals *compose a life.* Czarniawska (1997) has

used narrative to examine organizational change. Clandinin and Connelly (2000, p. 10) describe her work as using narrative as a "heuristic device" with which to explore organizations, and note that she offers narrative inquirers ways of seeing the world from yet another disciplinary stance.

Two further researchers are identified by Clandinin and Connelly (2000) as influencing their thinking about narrative inquiry, and are of particular relevance to this inquiry because of their work in the fields of psychiatry and psychology. Robert Coles, a psychiatrist, in his book *The Call of Stories* (1989) called for a revolution in psychiatry, one that focused on stories of lived experience rather than simply on diagnostic categories. Clandinin and Connelly (2000, p. 14) note that his use of stories – his own, patient stories, student stories and stories from the medical literature – differs from the other individuals they've previously discussed, in that his uses them in relation to his practice and teaching. Finally, the contributions of Donald Polkinghorne (1988), a psychologist and researcher, who asserts that narrative is the basis of the work that psychologists and other associated practitioners do, are described by Clandinin and Connelly (2000). They suggest that Polkinghorne's work on developing narrative theory, which incorporates history, literary theory and psychology, may also provide an example of ways of bridging research and practice (p. 17). All of these varied views are brought together by Clandinin and Connelly to define a research methodology of narrative inquiry.

The most recent, and extensive, account of the development of narrative inquiry appears in Clandinin's (2007) *Handbook of narrative inquiry: Mapping a methodology*. Part I of this handbook focuses on situating narrative inquiry both historically and alongside other inquiry methodologies. The first chapter, by Pinnegar and Daynes (2007, p. 9 – 28) looks at the development of narrative inquiry across time. They join a number of writers who have looked at the turn to narrative in research (Bruner, 1986; Polkinghorne, 1988; Sarbin, 1986). What they uniquely do in this chapter is to both identify four themes in the story of how narrative inquiry has developed as a research methodology, and also in the turns that an individual researcher may make as she begins to use narrative inquiry. These turns include:

1. changes in how the relationship between researchers and research participants is framed,
2. recognition of words as data,
3. increased understanding the importance of the particular, and
4. greater acceptance of multiple ways of knowing.

There is considerable diversity in what narrative inquirers do and in what their published research looks like. Clandinin (2007, p. xiii) notes the challenge the editorial team had in determining what *was* and what *wasn't* narrative inquiry when compiling the first narrative inquiry handbook. She further notes that the terms *narrative research* and *narrative inquiry* are frequently used as synonyms, although she and the editorial team

responsible for the *Handbook of Narrative Inquiry* had initially seen them as being distinct – one (narrative research) being an overarching term, the other (narrative inquiry) being a specific form of "relational" narrative research (p. xiii). More recently, some narrative inquirers (Caine, Estefan and Clandinin, in press) have become concerned that work named as *narrative inquiry* may very well not share the ontological commitments that Clandinin and others see as essential to understanding and undertaking this form of inquiry. This diversity of understanding, and of ontological commitments, also exists within the occupational therapy (OT) and occupational science (OS) literature when examining work named "narrative" and "narrative inquiry", and will be reviewed in the next section of this chapter.

The turn to narrative in Occupational Therapy/Occupational Science

Narrative approaches are also not new in occupational therapy and occupational science. Kielhofner and colleagues' development of a narratively-oriented occupational therapy assessment tool, the Occupational Performance History Interview (Kielhofner, Henry and Walens, 1989), Mattingly's (1991) discussion of the narrative nature of clinical reasoning, Mattingly and Fleming's (1994) research on clinical reasoning provide evidence of this interest from a clinical practice perspective. The thematic issue of the *American Journal of Occupational Therapy* (AOTA, 1996), focusing on narrative in therapy and research, also presented examples of narrative as

both tools for therapy and a research approach. Mattingly's (1998, 2007) continuing work on "healing dramas and clinical plots" and the use of narrative microanalysis provides another example of narrative used to explore practice. Clouston (2003) reviews the value of narrative approaches for both therapy and research in occupational therapy and suggests their value in both arenas. Molineux is currently editing a book on narrative research in occupation and health (Molineux, in press). Recently, Bonsall (2012) has explored the uses of narrative for OS and OT through a review of 95 articles about narrative found in the OT/OS literature. Based on his analysis of these articles, he suggests a typology of the uses of narrative in OS/OT that includes (1) narrative in everyday life, (2) narrative in clinical reasoning, and (3) narrative as research methodology. He comments that narrative methodologies are well suited to researching meaning and action. In reviewing the uses of narrative as research methodology, he suggests that these can be divided into narrative data or narrative inquiry. He then defines *narrative inquiry* as the way in which data is analyzed and suggests four types of narrative inquiry: thematic analysis, life history, narrative slope, and analysis of action. While Bonsall's review of the current uses of narrative is indeed useful, and may well reflect how occupational therapy researchers have been using narrative methodologies, his definition of narrative inquiry solely as a means of analyzing data is not at all consistent with the approach to narrative inquiry used in this study and reflected in the *Handbook of Narrative Inquiry: Mapping a methodology* (Clandinin, 2007). Clandinin

(2007) and the handbook contributors seek to position narrative inquiry as a methodology in relation to qualitative research approaches that are informed by post-positivist, post-structuralist and neo-marxist commitments. Clandinin and Connelly's (1999, 2000) search for a methodology to explore educators' and other professionals' practice has resulted in the development of a particular view of narrative inquiry that is broader than mere analysis of narratives, rests on Deweyian views of experience, and is deeply relational in nature. It is this perspective on narrative and narrative inquiry that guides my study.

The next section of this chapter will attempt to describe this view of narrative inquiry through describing critical design decisions that narrative inquirers undertake. I will illustrate these design decisions with examples from this inquiry. Woven throughout this discussion is further exploration of both the narrative inquiry literature and relevant occupational therapy and occupational science literature.

What is narrative inquiry and what do narrative inquirers do?

Connelly and Clandinin (2000) introduce narrative inquiry not so much by describing what it is, but rather by telling us what narrative inquirers do, often showing us about narrative inquiry in a storied form. They note that in this methodology, narrative is both the focus of inquiry and the method of inquiry (Connelly and Clandinin, 1990, p. 2). Clandinin and Connelly present

narrative inquiry as:

> a way of understanding experience. It is collaboration between researcher and participants, over time, in a place or series of places, and in social interaction with milieus. An inquirer enters this matrix in the midst and progresses in the same spirit, concluding the inquiry still in the midst of living and telling, reliving and retelling, the stories of the experiences that made up people's lives, both individual and social (Clandinin and Connelly, 2000, p. 20).

The centrality of experience in narrative inquiry is clear in this definition of narrative inquiry:

> People shape their daily lives by stories of who they and others are and as they interpret their past in terms of these stories. Story, in the current idiom, is a portal through which a person enters the world and by which their experience of the world is interpreted and made personally meaningful. Narrative inquiry, the study of experience as story, then, is first and foremost a way of thinking about experience. Narrative inquiry as a methodology entails a view of the phenomenon. To use narrative inquiry methodology is to adopt a particular view of experience as phenomenon under study. (Connelly & Clandinin, 2006, p. 375)

Contained within these explanations is Clandinin and Connelly's concept of a three-dimensional inquiry space for researching experience. Drawing from Dewey (1938) as he talked about understanding experience, they encourage

narrative inquiry researchers to consider (1) the personal *and* the social (what Dewey called *interaction,* and what they call *sociality)*, (2) the past, present *and* future (Dewey's *continuity,* and what they call *temporality)*, and (3) the impact of *place*. Narrative inquiry methodology as developed by Clandinin, Connelly and their colleagues rests on the assumption that:

> 'experience is the fundamental ontological category from which all inquiry—narrative or otherwise—proceeds' (Clandinin and Rosiek, 2007, p. 38). Working from Dewey's (1938/1997) view, they [Clandinin and Rosiek] describe experience as 'a changing stream that is characterized by continuous interaction of human thought with our personal, social and material environment' (Clandinin and Rosiek, 2007, p. 39). In this way, Clandinin and Rosiek note, Dewey's ontology is transactional, with revolutionary epistemological implications. They define a transactional ontology as one in which 'the regulative ideal for inquiry is not to generate an exclusively faithful representation of a reality independent of the knower. The regulative ideal for inquiry is to generate a new relation between a human being and her environment – her life, community, world—one that 'makes possible a new way of dealing with them. . .' (Dewey, 1981, p. 175). In this pragmatic view of knowledge, our representations arise from experience and must return to that experience for their validation' (Clandinin and Rosiek, p. 39). (Clandinin and Murphy, 2009, p. 598 – 599).

In other words, this focus on individuals' experiences across time, in interaction with personal, social and material worlds, is what characterizes narrative inquiry. Further, one of the ends of narrative inquiry is to offer new understandings and the possibility of new transactions between individuals and their environments, one that can only be tested through future transactions.

Narrative inquiry methodology: design considerations and their applications within the current study

As narrative inquirers design their inquiry, several aspects must be addressed. Clandinin and Huber (2010) outline some of the most critical: justification, naming the phenomenon, living the inquiry, positioning, ethical considerations and representation. In this chapter I will review each of these considerations and describe them within the context of my study.

Design consideration: Justification

In designing their study, inquirers will consider personal, practical and social justifications for the inquiry. What does this inquiry mean to and for the inquirer's life? Is there the possibility that the inquiry could impact practice? Looking at possible social justifications for the research, could the inquiry contribute to new methodological and/or disciplinary understandings? What social actions or policy changes might come from this inquiry?

Narrative inquirers frequently enter into their research through "narrative beginnings" which serve to explore their experiences relative to their research interest. In the course of these narrative beginnings, inquirers reflect backward to their own practice stories and their "stories to live by" and begin to articulate the justification for the inquiry they are about to undertake. They are also likely to look forward and consider how what they are choosing to inquire about may link to their future practice.

These narrative beginnings also help the inquirer to develop a wakefulness to how her/his experiences may interact with stories lived, told, retold, and relived throughout an extended narrative inquiry process. This form of writing is often quite different from that the inquirer may have used in previous work; writing narrative beginnings provides her/him with an opportunity to explore and develop a more narratively oriented "voice".

My narrative beginnings are found in the first chapter of this dissertation and are my exploration of stories within specific practice landscapes that I inhabited, as I thought about researching occupation-based practice. It was through these beginnings that I came to develop a set of research wonders, and reflected on my motivations for undertaking such a venture. This writing also provided me with an opportunity to explore writing that was very different from anything I had written in an academic context before, and to develop some sense of a different "voice". As I wrote and shared these narrative beginnings I discovered how much, even though I do not have extensive research experience, I had incorporated one story of

how research happens and in what voice research findings are re/presented. I wondered if I would be perceived as one of those "inquirers who forget their participants and write only for themselves and become narcissistic" (Clandinin and Connelly, 2006, p. 485). I felt more than a little exposed, but looking backward, I think this was helpful in sensitizing me to how my participants might feel as I shared their stories of experience in the research text.

In the first chapter of this dissertation, I explored the personal, practical and social justifications for an inquiry into occupation-based practice. I told and retold stories of my experiences with occupation-based practice, and my concerns about how my experiences in clinical practice may influence me now and in the future, as an educator of occupational therapists. I briefly presented some of the research and rhetoric within occupational therapy about practice, and considered how a narrative inquiry might further understanding of how occupational therapists practice occupationally, and thus potentially support changes in practice. Issues of moral distress, therapist burnout, problems with retention of occupational therapists, tensions that lead to "underground practice", were all things I considered in designing this inquiry. At a larger level, my concern is that people who might benefit from the unique contributions occupational therapy *could* offer might not be able to access it due to therapists leaving the profession and/or practicing in ways that do not reflect the unique contributions that occupational therapy can bring to healthcare. Thinking about social

justification led me to think about theoretical justification – whether this inquiry might provide an example to scholars of what narrative inquiry methodology can contribute to studying occupational therapists' practice, and provide new knowledge about therapists experiences of occupation-based practice. I also wondered how this study might contribute to curricular discussions within occupational therapy education.

Design consideration: Naming the phenomenon

The inquirer moves onward from justification to naming the phenomenon. Through the writing and reflection that narrative beginnings allow, researchers are also beginning to articulate the research "puzzles" or "wonders" that they will explore – narrative inquirers are less likely to use the terms "research question" or "research problem", with the implication that questions have definitive answers and problems have clear solutions (Clandinin and Connelly, 2000, p. 124).

In this inquiry, naming the phenomenon meant looking both backward and inward through my narrative beginnings, and outward to the occupational therapy literature and ongoing dialogues within the profession that happen where occupational therapists meet, in day-to-day discussions with peers and students, in conference hallways and in online venues. It involved exploring definitions and use of terms such as *occupational therapy*, *occupational science, occupation*, *co-occupation*, *occupation as means/ends and occupation-based practice*. In this naming process, I also looked

backward to the history of the profession of occupational therapy, and to ongoing discussions within the profession about occupation-based practice.

In naming the phenomenon about which I was interested in learning more, I also needed to further explore and name the inquiry approach that I planned to use. I could articulate what I was interested in, and why occupation-based practice was important to me, to therapists and to clients/families and the healthcare team, and that a study of occupation-based practice might lead to changes in practice. Less clear to me at that early stage was what narrative inquiry is, and how this methodology could help me with my specific wonders. As I explored narrative approaches, I slowly gained an appreciation of the diversity within the research named as *narrative* or even within the work specifically labeled *narrative inquiry*. I was fortunate enough to take a narrative inquiry course with Jean Clandinin, and to spend many Tuesday lunch-hours at the *Research Issues* table, listening to neophyte and experienced narrative inquirers from across campus and around the world share their work and their wonders in that response community. Through taking the course, participating in the rich discussions at the *Research Issues* table, extensive reading of articles, research proposals, dissertations, book chapters and the *Handbook of Narrative Inquiry*, I came to some (incomplete and still provisional) understanding of narrative inquiry as Clandinin and Connelly and their many colleagues have been naming and framing it. This naming and framing was crucial as, beyond knowing what wonders I was describing in which professional knowledge landscapes, I also

needed to have some sense of how I was situated within the research landscape, and what borderlands I might bump up against within this inquiry. The concept of borderlands is important and will be discussed in more depth later in this chapter.

Design consideration: Living the inquiry

The Field

The narrative inquirer may take one of two approaches to continue her inquiry. This choice is made early in designing the inquiry. The first approach starts with the inquirer listening to stories told of lived experience. The second begins with the inquirer coming alongside participants in a time and place – to live stories with participants and others in the landscape. In the *Handbook of Narrative Inquiry: Mapping a methodology*, Clandinin (2007) provides examples of both starting points. Inquiries that begin with the telling of stories might be, for example, stories told in psychotherapy (Rogers, 2007), or autobiographical stories (Freeman, 2007) or life history stories (Atkinson, 2007). Initial design decisions about how to start this narrative inquiry, and ongoing decisions about the living of this inquiry truly reflect that this inquiry, as do all inquiries, unfolded in the midst of ongoing lives. The impact of illness, death of parents and a grandparent, birth of a grandchild, job loss, job change, work stress, travel plans, distance, academic projects and retirement on the individuals involved in this inquiry meant that some initial plans needed to be modified.

My exploration of occupational therapists' experience of "doing occupation" within practice started with stories of lived experience of the research participants (the four occupational therapists I recruited as participants and myself as the researcher). Given the busy clinical environment of two of the participants, that one participant was retiring and that another no longer worked in a clinical environment, I felt that the most likely means of exploring my wonders was through listening to and sharing stories of practice in an out-of-hospital setting. I also thought that this sharing might be facilitated by meeting over a meal, and through some collective doing of an occupation. I met with each participant individually to explore her stories of practice. These meetings were from just over an hour to more than 3 hours in length. They took place at participants' homes, at my home or, with one participant, in my office at the university. These discussions were transcribed verbatim. Excerpts from these discussions are indicated in this dissertation with brackets around the participant's initial. During the inquiry process, three participants chose a name by which they wanted to be called. Based on what I knew about the fourth participant, I gave her a pseudonym (Alegría) which she confirmed fit her: "I love my new defined me as 'Alegría' - thank you!" (Alegría, personal communication, November 6, 2012). The participants and I met as a group on three occasions to share and discuss practice stories with each other in more detail through both word and image. These "research dinner parties" took place at my house, over a meal. They typically lasted from 2 to 2.5 hours. One participant

did not attend in person, as she lived too far away to make the trip practical. She participated by sharing a digital story, a recorded conference presentation, through sharing some documents she had developed in her workplace and by "Skype™-ing in" to part of one research dinner party. A fourth meeting involved only two participants and the researcher – during this meeting the participants and I created collages representing their understandings of occupation. These research dinner parties appear in this dissertation as, for instance [DP1], [DP2], [DP3] and [CM] – collage making. I make an occasional appearance in the transcribed discussion – indicated with [S]. Excerpts from a digital story shared by one participant are indicated with [DS]. Excerpts from a conference presentation are marked with [CP]. All research group meetings were audiotaped; not all of the conversation was transcribed, for instance discussions of the meal, upcoming vacations, conversations about other research ventures, family commitments, etc. were not transcribed.

The second approach to narrative inquiry, beginning with the living of stories, might involve, for example, the researcher joining a teacher in a classroom for a semester or longer. This typically goes beyond mere observation, and involves the researcher as an active participant in the setting in ways determined through negotiation with the teacher(s) and other school staff, students and families. Craig and Huber (2007) provide several examples of narrative inquiries that started with the living of stories and discuss the relational intricacies of this type of inquiry. If my inquiry into

occupation-based practice had started with the living of stories, I might have followed the lead of Price (2003), who both observed her participants within a variety of clinical settings and interviewed the occupational therapists and parents of the children these therapists worked with. While Price came "alongside of" her participants, she was still clearly an observer, unlike the examples provided by Craig and Huber (2007), or those in Clandinin, Huber, Huber, Murphy, Orr, Pearce and Steeves (2006) in which the inquirers are more involved in the day-to-day life of the classrooms and other school places in which they are researchers. I did not chose this second approach for the reasons noted previously, and because I thought it would feel safer for participants to share what I expected might be stories of "underground practice" somewhere off the practice landscape.

Somewhat ironically and heart-breakingly, although I had not intended as part of the inquiry process to enter into healthcare settings similar to those in which my participants had or were working, and to those I had worked in before becoming an educator, my father's illness and dying took me into three units in an acute care hospital and the hospice unit of an extended care centre, just as I had started interviewing my participants. While none of these were places where my participants had worked, being in these places did help me to better understand the landscapes in which the stories that were shared took place.

Field texts

Regardless of whether inquirers start with the telling or living of

stories, Clandinin (2006) points out that narrative inquirers always enter in the midst of stories – those of their participants and their own. In addition to transcripts or other records of the stories told by and with participants, the narrative inquirer creates field texts that allow the inquirer to move back and forth between being close to, and more removed from, her participants. A field text might include, for example: transcripts of recorded conversations, the researcher's field-notes, photographs, poems and creative artifacts produced by participants and researcher. Field texts allow the inquirer to record the specifics of her time with her participants, her thoughts at various times throughout the inquiry process and experiences as she moves between "falling in love and slipping to cool observation" (Clandinin and Connelly, 2000, p. 81).

In my study of occupation-based practice, field-texts included a journal, notes written after each discussion with a participant, and after each research group meeting, transcriptions from one-to-one discussions as well as group meeting discussions, comments from participants on their own interview transcripts, a digital story shared by a participant, an audiotaped conference presentation, an article written by one of the participants and shared with me and with the other participants, collages produced by two participants, as well as research poems and images.

Field texts to interim research texts

In living the inquiry, the research process moves from fieldwork to

production of interim research texts. This move from "falling in love to slipping to cool observation" does not mean that the inquirer is no longer working in relationship with participants and experiences shared and co-created. Interim research texts are developed, holding fast to an ontological commitment to exploring the narratives of experience shared by participants. As Bateson (1989, p. 10), cited in Clandinin and Huber (2010) notes: "Dissection is an essential part of the scientific method, and it is particularly tempting to disassemble." The narrative inquirer may feel drawn at this point to consider thematic analysis across stories, or focus on discourse, or get caught up in analysis that seeks to identify actors, plots and other literary elements. Clandinin and Rosiek (2006) eloquently discuss the tensions that narrative inquirers working in the "borderlands" between narrative inquiry and other inquiry traditions may be especially aware of at this part of the inquiry process. These tensions will be described further in the section on positioning in this chapter.

In this phase of the inquiry, I shared interim research texts with participants via e-mail. These interim texts included first a recounting of their stories. I asked participants if what I heard and made of what I heard was in line with their living and telling of their stories of occupational therapy practice. Considering all of the possible stories I had heard from each participant, or that we had lived as part of the inquiry process, I then chose specific stories of practice that seemed to me to be particularly relevant to the wonders about the experience of occupation-based practice that I was

exploring. After retelling these stories within a three-dimensional inquiry space, I again asked participants to comment on what I had written, and revised with their comments in mind.

Interim research texts to research texts

One convention of narrative inquiry is that in research texts, honoring the ontological commitment to focus on narrative as a representation of experience as much as possible, participants' narratives are presented narratively. They are not simply mined for themes, with the stories that these themes are gleaned from left aside as mere debris.

The research texts in this inquiry have attempted to honor this commitment. Each participant's narratives of practice are presented in a separate chapter as a *narrative account*, that starts with an introduction to the participant and her practice as an occupational therapist, then explores stories from practice that I identified as having the most relevance to my research wonders. This exploration uses as a framework the three commonplaces of temporality, sociality and place to inquire into stories lived and told by participants.

Design consideration: Positioning

As Clandinin, Pushor and Orr (2007) and Clandinin and Huber (2010) note, another design consideration is about positioning: positioning the inquiry in terms of other research related to the wonders the inquiry seeks to explore, to related research and to research undertaken from different

ontological and epistemological stances. As part of this narrative inquiry, I read research about occupation-based practice including, for example, work by Price and colleagues (Price-Lackey and Cashman, 1996; Price, 2003; Price and Miner, 2007; Ward, Mitchell and Price, 2007; Price and Miner, 2009); work by Mattingly and colleagues (Mattingly, 1998; Mattingly, 2010; Mattingly and Fleming, 1994; Mattingly and Garro, 2000); Fisher's work (2003, 2009); and articles, presentations and books by Molineux (2001, 2004, 2010, 2011) which specifically address concerns about occupation-based practice. Many of these are cited in the first chapter of this dissertation.

I also read widely in the occupational therapy literature about job satisfaction, therapist identity, changes in the healthcare system, the history and philosophical under-pinnings of the profession, for instance, Abreu (2006); Cutchin (2004); Friedland (1998); Gupta, Paterson, Lysaght and Von Zweck (2012); Hammell (2009); Hocking (2004, 2007, 2008); Mackey (2006), and Wood (2004) amongst many others. These works and others are likewise discussed throughout this dissertation. Reading or re-reading these authors provided me with particular perspectives on occupational therapy theoretical and practice landscapes. Some of these ideas resonated with my own experiences as an occupational therapy clinician and administrator. Some did not. Some took me back to my earlier graduate study experiences and the rich opportunities to examine practice I first found there. In addition to reading in the occupational therapy literature, I found myself drawn to

ethicist Nelson's ideas about chosen communities, resistance and insubordination, and about narrative repair (1995, 2001). I also was reminded of Bateson's writing about ways women compose their lives (2001) as I lived and thought through this prolonged inquiry process.

As I positioned myself within this inquiry, I also read about research explicitly named as *narrative inquiry* within the occupational therapy/occupational science literature. While there is greater awareness and use of narrative approaches in general in occupational therapy practice, specific examples of research using narrative inquiry, as I am coming to understand it, are somewhat more difficult to find. Even though Peirce, Atler, Baltisberger et al. (2010) list *narrative inquiry* as the second most common qualitative research methodology used by researchers presenting at the Society for the Study of Occupation: USA (SSO: USA) it seems very likely that many different approaches to narrative inquiry are subsumed under that category. Turning to the published literature, including dissertations, Taylor (2009, p. 41) states that she used narrative ethnography (Tedlock, 1983) in her study of the stories of siblings of persons with schizophrenia, however she also clearly refers to the three "commonplaces" – temporality, sociality and place (Clandinin, Pushor and Orr, 2007, p. 21) of narrative inquiry in describing her research process. Hewitt, Howie and Feldman (2010) describe their research into individuals' pre-retirement planning as using narrative inquiry and say that they used interviews and subsequently undertook "paradigmatic-type narrative analysis [that] led to the development of

categories and subsequent themes to reveal the participants' experiences" (p. 8). They do not cite a specific methodology, although they do reference Polkinghorne's (1995) work on narrative within qualitative analysis. An interesting article by Savin-Baden and Niekwek (2007) reviews narrative inquiry and provides a brief discussion of how it could be used in occupational therapy education. To date it appears there is only one study (Harris, 2007) that names narrative inquiry as the methodology used to look at an occupational therapist's work – specifically, the meaning of craft in one occupational therapist's practice. Harris (2007, p. 3) says that her study is: "situated in the interpretive paradigm guided by the phenomenological approach" (Taylor, 2000) which is again dissimilar to the way in which narrative inquiry is framed and used within this inquiry. These examples reflect the diversity of narrative approaches presented under the flag of narrative inquiry within occupational therapy. Published examples of narrative inquiry research as described by Connelly and Clandinin (1999) remain scarce in occupational therapy. Given my sense that this form of narrative inquiry had much to offer, the opportunity to experience the narrative inquiry process as a researcher was one of my motivations for undertaking the work presented here, even though I had some small sense of the tensions I would experience as I worked alongside the borderlands that exist between narrative inquiry and methodologies informed by other ontological and epistemological commitments.

Because occupational therapy is a health profession, I also did some

exploration of narrative inquiries done by other healthcare professionals. Caine (2002), a nurse educator, used visual narrative inquiry to share the experiences of First Nations women living with HIV. Estefan (2008), also a nurse and educator, used narrative inquiry to look at self-harm in young gay men. Barton (2004) used narrative inquiry in exploring how nurses could better understand first nation people's "diabetic self" stories (p. 519). Reissman and Speedy (2007) critically review narrative research in social work, counseling and psychotherapy. Bach and Baydala (2006) used visual narrative inquiry to look at the lives of young women and of children living with obesity.

Finally, I read within and outside the occupational therapy literature about ontological and epistemological positions taken by researchers. Some of this exploration was to gain an understanding of how occupational therapists and occupational scientists had framed, and were framing, their research. For instance, Pierce, Atler, Baltisberger et al. (2010) reviewed research presented over five years at the Society for the Study of Occupation: USA and found that occupational science/therapy studies presented there used qualitative methodologies much more often than quantitative and mixed method methodologies (84%, 7%, 9%). Within the studies identified as qualitative, grounded theory (19%), narrative (7%), phenomenology (7%) and ethnography (6%) were the most commonly identified methodologies. Frank and Polkinghorne (2010) suggest that after three decades of qualitative research in occupational therapy, current researchers need to

more closely examine how research and social theories interact, gain more expertise in attending to language, attend to contexts, utilize observation and become participants in scholarly debate both within and outside occupational therapy (p. 51). They suggest that narrative approaches are key elements of what they call a "second generation" of occupational therapy research that will shape practice. Included in this discussion of second-generation research are examples of research using discourse analysis, an approach that Clandinin and Rosiek would see as existing in the borderlands between narrative inquiry and post-structuralism, as will be discussed briefly later in this chapter.

Some authors have encouraged occupational therapists/scientists to gain a greater ontological and epistemological awareness, for example Hooper (2006), Galle and Whitcombe (2006), and Kinsella and Whiteford (2009). Most of my reading outside the occupational therapy/science literature was done in qualitative research coursework, or in an arts-based research course. These readings, taken together, have helped me move towards what is still a provisional understanding of narrative inquiry and have thus affected my positioning on the research landscape. I share again some of that understanding, as well as review some of the tensions that narrative inquirers may experience as they undertake their work.

Narrative inquiry as a methodology for exploring and changing practice

As developed by Clandinin, Connelly and their associates, narrative

inquiry was concerned initially with exploring teacher knowledge, context and identity (Connelly and Clandinin, 1999, p. 1) and the lives of students in school landscapes. These inquirers, themselves teachers, administrators or teacher-educators, were deeply interested in teachers' *personal practical knowledge* – the "body of convictions, and meanings, conscious or unconscious, that have arisen from experience (intimate, social and traditional" (Clandinin et al. 2006, p. 5). They wanted to know more about the landscapes in which teachers worked, along with the "sacred" and "cover" stories told in those landscapes. They were interested in how teachers responded within their classrooms to external prescriptions coming from school, district or government administrators – what they have referred to a messages from a metaphorical *conduit* (Connelly and Clandinin, 1999). Clandinin and Connelly (1995, p. 125) talk about "competing" and "conflicting" stories in these classroom landscapes. Competing stories pit two stories that can co-exist in dynamic interaction with each other. Conflicting stories, on the other hand, do not so safely co-exist; they are bumping up places where the dominant story is in opposition to the story of the teacher. These situations often lead to the telling of cover stories by teachers. They inquired into teacher identities as teacher "stories to live by", which they describe as the tie that binds knowledge, context and identity together (Connelly and Clandinin, 1999, p. 4).

In reading these studies, it is clear that these researchers were also passionate about the possibilities for making school an educative rather than

mis-educative experience. This emphasis on research *for* practice rather than research *about* practice (Noddings, 1986, p. 506) speaks to an intent that narrative inquiry should be useful for researcher and participants as well as the wider social world in which they operate. Clandinin (2006, p. 53) comments on her hope that her research will "change the world, at least in some small way, a way that might help schools become more educative places for all children, teachers, families and administrators." While McNiff (2007) draws parallels between narrative inquiry and action research as transformative tools for scholar-practitioners, Clandinin notes that the question of whether narrative inquiry is descriptive or interventionist is ongoing within the field (Clandinin, 2007, p, xv). My intent here is to be interventionist, in the sense of perhaps effecting some increased ability for resistance and insubordination within myself, and, perhaps, within the participants who joined me in this venture and, potentially, within those who read about this inquiry. This activist stance is congruent with occupational therapy's focus on doing, being and becoming through occupation. The doing of the inquiry (living, telling, re-telling and possibly re-living of these stories) is engaging in occupation.

On the borderlands of narrative inquiry

As Clandinin and Rosiek (2007) note, and has been briefly mentioned above in reviewing published studies named narrative inquiry, there are multiple interpretations of narrative inquiry in social science research (p. 37)

and tensions in the borderlands between narrative inquiry and post-positivism, neo-marxism and post-structuralism (p. 43). They describe the idea of borders and borderlands between narrative inquiry and other forms of inquiry, and attempt to locate narrative inquiry in relation to those borders and borderlands. They comment on some of the tensions that narrative inquirers may experience as they undertake their work.

What are the implications of these borderland tensions for narrative inquiry undertakings in general and specifically for this inquiry into occupation-based practice? Clandinin and Rosiek (2007) suggest, for instance, that some researchers labeling their work as narrative inquiry may, in travelling through the borderlands between narrative inquiry and post-positivism, succumb to a temptation to use stories primarily as a means to identify a universal case and over-arching themes. Further, inquirers working in the borders with post-positivism may be drawn to attending to patterns and trends from stories lived and told. A narrative inquirer, on the other hand, holds as central the focus on experience and would see such uses of narratives as a sundering of person and story from time, context and from possibilities of transformation. For instance, this framing of narrative inquiry would suggest that the chances that someone can move from living/telling to a transformed re-telling/re-living of narratives is less likely when her/his own story has been reduced to a set of themes/common principles and is no longer her/his story. This search for themes and trends is one of the tensions that was experienced in completing this narrative inquiry into occupation-

based practice, and can perhaps be represented in this poem written as I moved from writing interim research texts to research texts. The poem, “Dawn, Dissected”, is included in the Epilogue, in the research poems section. I had written about one of the participants, Dawn, but had pulled or lifted threads/themes to such a degree that her stories had almost disappeared. I was anxious, and that anxiety pushed me into living out some of this inquiry journey into one of the borderlands. Clandinin and Rosiek (2007) suggest that narrative inquirers working in this borderland sometimes react in these ways as a response to the anxiety they experience within the narrative inquiry space as they encounter ever-expanding counter-narratives.

Clandinin and Connelly's (2000) story of their experiences while working with the Bloom's Taxonomy revision team suggest another concern. They wonder if narrative inquirers may, in working in the interstitial spaces between narrative and positivist/post-positivist methodologies, come to worry that their thinking is “weak, effete, and soft: somehow lacking in rigour, precision and certainty” (p. 27). Might this lead to inquirers becoming self-silencing, saying less than they might have otherwise; or self-editing, adopting ideas and language more in line with post-positivist traditions? This tension was present within this inquiry.

In the borderlands between narrative inquiry and neo-marxism, tensions might also arise from differing views of individual experience as a valid form of knowing by narrative inquirers – something those more steeped in neo-marxist methodologies might claim is not possible given the distorting effects

of ideologies (Clandinin and Rosiek, 2007, p. 48). This tension was present in my concerns about how to inquire into both the personal *and* the social, and whether I was attending to both equally. It was present as I read some of the work of critical theorists like Hammell (2009, 2010) and wondered if I was being naïve.

Finally, Clandinin and Connelly (2000) identify a number of ways in which tensions between narrative inquiry methodology and formalist/post-structuralist methodologies may play out at all phases of a research undertaking. For instance, as the research is framed, formalists will focus on theoretical framing of the *problem*, whereas narrative inquirers are more likely to ground their initial work in experience as presented in story, to explore their own experiences in "narrative beginnings" that lead to description of research *puzzles* or *wonders*. Other tensions in this borderland appear as disagreements about (1) the sequencing and placement of literature reviews, (2) the balance between theory and experience, and (3) about viewing individuals as themselves or as exemplars of a larger group. These tensions were also experienced during this inquiry as I explored what narrative inquiry is, and negotiated that understanding with my supervisors and participants.

Clandinin and Connelly (2000) further caution researchers that our histories as inquirers will influence our work – whatever territories we may have travelled in before may be ones we tend to return to in future inquiries. Most of my past research experience has been in using either quantitative

approaches coming from a positivist tradition, or qualitative approaches which were perhaps somewhat methodologically murky in terms of their ontological and epistemological commitments.

Current "hot topic" discussions within the profession might also influence inquirers. For instance, when considering narrative inquiry into occupational therapy practice, several occupational therapy authors have taken a critical theory approach – for instance, recently Hammell (2009, 2010) has been particularly articulate in viewing issues in practice with a critical theory lens. Pollard, Sakellariou and Kronenberg (2008) describe a "political practice of occupational therapy" and the use of "3P (*p*ersonal, *p*rofessional and *p*olitical) archeology" (pp. 3-4) as essential for contemporary practice. Nelson (2007) used critical race theory to examine occupational therapy services with indigenous Australians. While I have read these authors, and find they have much to offer, within this inquiry I will not be travelling extensively in the borderlands between narrative inquiry and critical theory and other associated countries that Clandinin and Rosiek identify under the label neo-marxist.

Clandinin and Rosiek (2007) describe one additional borderland tension. They note that the borderlands between narrative inquiry and post-structuralism are particularly well inhabited. They suggest that the tension for a narrative inquirer approaching the borderlands with post-structuralism relates to an attraction to fitting stories to a metaphor or to a particular discourse. Mackey's (2006) discussion of occupational therapy identity

provides one of a few examples within the occupational therapy literature of this interest in discursive practices within the profession. Hooper and Woods (2002) describe two dominant discourses in occupational therapy and Hocking (2004) discusses Romanticism (from the ideas of the Romantic movement of late 18th and 19th century Europe) and rationalism as competing discourses within the profession.

Clandinin and Rosiek (2007) also give us a taste of the rhetoric from within each inquiry tradition that can create a hardening of the intellectual arteries and/or serve to silence entirely those working in the borderlands. The sticks and stones that accuse other inquirers of not being theoretical enough, being naive, being overly concerned with issues of class/race/gender, not being aware of, or serving, vested interests, being condescending, do not serve anyone well, except perhaps those with a vested interest in stilling interpretivist inquiry altogether. Perhaps, as Lugones (1987) suggests, we need to remind ourselves about play, "world-travelling" and loving rather than arrogant perception? Cheek (2007) provides a good discussion of quandaries for individuals engaging in qualitative research in general, and suggests we need to cautiously consider the reasons for the choices and positions we take, the spaces we occupy or the answers we give (p. 1058) in order to continue working in spaces "rather than being worked over by them" (p. 1052). This was evident in this study, as I struggled with anxieties that came from wondering if I was smart enough, if this was really research, if I shouldn't be analyzing the transcripts for themes, if I was being

naïve about social and political influences, or whether I was just engaging in an obsessive narcissistic life review. I don't think I was alone in these worries.

Design consideration: Ethical considerations

Clandinin and Huber (2010) describe the way ethical considerations play into designing a narrative inquiry. The deeply relational nature of this inquiry journey requires outgoing attention to the lives of participants and inquirers throughout the research process and into the future. Within the research process, this means not stopping at getting informed consent at the beginning of the process, but continuing to attend to this throughout. One of the many ways this plays out is in the production of research texts, with the inquirer keeping in mind issues such as anonymity and confidentiality and what stories say about who this person is and is becoming. Participants read and comment on interim and final research texts within the context of an ongoing relationship. An ethics of care guides the inquirer as research texts are written.

In this narrative inquiry, participants read and commented on initial discussion transcripts from my one-to-one meetings with them. One common response was mild dismay about the verbatim scripts in terms of "ah's" and "um's". Participants felt they didn't sound very articulate. Taking that concern into consideration, I did edit some of these interjections out, except where they particularly seemed to me to show a long pause or some tension, where the speaker appeared to be reflecting on how to answer a question or respond to a comment. All participants have a pseudonym; all had some

names, places or situations that they talked about in the interview or during the research dinner parties that they wanted omitted or obscured. This sometimes came up as they were in the midst of telling a story, and other times when they were reviewing a transcript or an interim research text. I shared interim research texts with participants, and asked for comments or concerns as I wrote these texts.

Design consideration: Issues in representation

The final design consideration that narrative inquirers must attend to is that of representation in the research text. How will the inquirer represent what they have heard and discussed and learned within the final research text? In making these design decisions, the inquirer must think about at least six aspects (Clandinin, Pushor and Orr, 2007, pp. 31-32):

1. continuing to think narratively using the "three commonplaces";
2. what possible forms the text might take, given a specific inquiry;
3. how, at a different time, in other circumstances, and for varied purposes, the research text might be considerably different;
4. who the multiple audiences for this work are;
5. how the quality of the research text might be judged; and
6. the social implications of their work.

In this inquiry, I attempted to continue to work narratively, considering temporality, sociality and place as I explored my participants' and my own experiences of occupation-based practices within specific landscapes. I considered various textual forms, and,

given what my purposes and audiences were in this initial representation of my inquiry, chose a more "conservative" stance than I might in some future re-telling. Two of the participants and I did use photographs and collage as a means of exploring our understandings of occupation itself, but these highly personal works are not included in this text.

Clandinin, Pushor and Orr (2007, p. 32) note that many narrative inquirers discover within the research process, a metaphor that may be particularly useful for them in structuring their research text. In this inquiry, I explored map-making and collage as possibilities. As a bead-maker and jewellery designer, I initially thought about how I might use beads and jewellery in undertaking and representing the inquiry. I did make the collages that participants assembled into wearable miniature photo albums, a shared reminder of our discussions about occupation. As a "basket-weaver" (a pejorative term sometimes applied to occupational therapists) I initially considered and resisted the image of basket making as a metaphor for the inquiry. Still, I kept being drawn back to it, and started reading about coiled, beaded baskets. The more I read, the more I could see how this metaphor might help me in reflecting on the narrative work that I was undertaking. I wrote more about this metaphor as I was in the midst of preparing the research text. This reflection is included in the Epilogue of the dissertation. The idea of a coiled basket is represented symbolically in the narrative accounts

that follow by the symbol ⊙, which I use as a reminder that the core of this inquiry is experience, around which are wrapped narratives. Thus this symbol represents a cross-section of one of the coils of the basket, and is used to separate specific experiences that participants shared with me and with each other. I also wrote several research poems and continued to make journal entries that helped me in thinking through the process of being in the midst of a narrative inquiry. Some of these were shared at the Research Issues table. Responses from those around the table frequently gave me new insights.

As to considerations of quality, I considered the three commonplaces, the critical design elements (Clandinin and Huber, 2010), responses from participants, and responses from those reading and listening to the research text. These included both individuals familiar with narrative inquiry as well as those who had no experience with this methodology. My response community included not only people that I could sit with in a face-to-face setting, but other occupational therapists/scientists in my online community. In both of these contexts, I attended to my ethical commitment to my participants, taking care not to expose them to this larger world. In two social situations where I was present, a participant shared with some social acquaintances that she was involved in my study. As I wrote the research texts I was attentive to representing each participant, myself and the inquiry itself in a way that showed authenticity, adequacy and

plausibility. Attending to resonance came through being wakeful to stories that were most resonant within the participants' telling, between participants and with my own experience. Whether others find this resonates with their experiences of occupation-based practice remains to be seen, and will be one of the most important outcomes of sharing this inquiry journey through this dissertation and through other publications and presentations that arise from it. These markers of quality will influence the social value of the inquiry beyond its transformative mark on me, and perhaps, my participants and committee members as they have journeyed along with me.

Summary

In this chapter, I have attempted to describe narrative inquiry and its usefulness for examining practice, discuss decisions narrative inquirers must address as they plan and live out an inquiry, and describe how these design decisions relate to this particular inquiry. I have spent time looking at the positioning of this narrative inquiry in relation to other research related to occupation-based practice, to other research and debates within occupational therapy, and considered this inquiry in relation to ontological and epistemological stances within the occupational therapy profession. I have briefly introduced a possible metaphor; this metaphor will be discussed much more thoroughly in a final reflection in the Epilogue.

The next chapter in this dissertation will be an inquiry into the experiences of occupation-based practice of Katherine, a recently retired occupational therapist who was the first participant recruited for this study.

Chapter Three: Katherine

Introduction

This narrative account starts by introducing Katherine. Four stories relevant to *doing occupation* from her long and diverse practice as an occupational therapist are re-told, and form the basis for inquiring into her experiences. Using the three-dimensional narrative inquiry framework as a guide I travel backward and forward looking at temporality, inward and outward to examine interactions between the personal and the social (sociality), and explore a variety of practice landscapes and places within Katherine's stories. I look for continuities and discontinuities in how Katherine is *doing occupation* and how her stories to live by, and her personal practical knowledge, bump up against other competing or conflicting stories (Clandinin and Connelly, 1995) in the healthcare, legal and professional knowledge landscapes.

Introducing Katherine

Katherine is a recently retired occupational therapist, mother, grandmother, traveller, photographer, volunteer and active church member, amongst many other roles. She lives in the western Canadian city to which she moved from elsewhere in Canada early in her career as an occupational therapist. She has been a front-line therapist, work evaluator for a not-for-profit agency, co-owner of a group practice, department director, and for a

significant portion of her career, an occupational therapy consultant doing medical-legal work, both within an organization and as a sole practitioner. In many of these things she has been a pioneer locally or nationally. She has been active both provincially and nationally with occupational therapy professional organizations throughout most of her career, and has taught occupational therapy students as a guest instructor and as a fieldwork supervisor. She also worked for a time in a clinic affiliated with a university.

While I have never worked with Katherine, our paths have crossed frequently and I now sing in a choir with her. When I approached her to ask her if she would be interested in participating in this research, she responded that she'd be interested but wondered if she would have enough to contribute given that, during a significant part of her career, her primary role was to assess individuals rather than to work with them to achieve their occupational goals. She was the first person I interviewed, and was an active participant in all three research group dinners, as well as the evening where two participants and myself made collages from photographs they brought and/or magazine clippings and printed words. Katherine knew one of the other research participants from having worked with her briefly many years ago. The other two participants were not people she had met before.

Katherine had stopped taking new clients before we started working on this inquiry, and now is officially retired from occupational therapy practice. She recently became a grandmother. Katherine volunteers as a literacy tutor for adults. She sees this as one way of continuing to use the skills she has

developed as an occupational therapist. During the research process she travelled to India with an OT friend for a month. She has also recently joined a photography club and is enjoying the regular challenges that the club sets its members.

I explore four of Katherine's practice stories in this chapter: a story of playing, a story of working, a story of making coffee and a story of learning more about a bird-house maker. Given Katherine's long career, there are many stories she told that I could have included in this inquiry. I chose these four because they seemed to me to say the most about Katherine's experiences with doing occupation.

Playing: Daily activity programs

Katherine told this story of one of her experiences as a student. She had travelled across Canada to do her fieldwork at a hospital that, at the time, had many First Nations clients from northern Canada. She says of that place and time:

> [K] So the two of us were at the hospital working under [the OT] and she had us do a recreational programme for the young native kids who were there doing tuberculosis [TB] treatment. And who, frankly, were fine. They could've gone home as long as they would have completed another six months of drug treatment. But they knew they couldn't reliably send them home and make sure they would complete it. Here they were in hospital and they were basically normal healthy kids with no play programming and no playroom even – they were in a hospital. And the community wasn't keen on having them in the playgrounds or anything – you know, the community was still very scared of TB. And so we created – I'd just come from two summers being a day camp counsellor, which really was quite helpful - and my other OT partner and I created sort of daily activity programs so the

> kids could run around in the gym and burn off some energy and be playing games. And it only occurred to me this year – it hadn't even crossed my mind - that we never ever took advantage of the other native people there to ask about what their games would have been. That just sort of shook me, to realize how insular we were and really culturally – I mean we knew it was a different culture but I never thought of working at it from the other direction. Oh and I feel, oh, I wish I could have done that one again!

Katherine and her classmate were asked to design and supervise a recreational programme for young First Nations children with TB. The children were not able to go home to the North because there was concern that their TB treatment would be compromised, nor were they able to go out into the community surrounding the hospital, because people there were afraid that these children might still be contagious. Given Katherine's experience as a camp counsellor, designing activity programming wasn't difficult for her. She used what she knew to design activities in the gym and do crafts:

> [K] My knowledge of crafts and songs and games from day camp got put to immediate use. And just the experience I had gained working with kids in that age group - that really was really useful.
> We made things with gimp [laughs] – lacing, it's leather, it's plastic stuff and you can make lanyards and bracelets and that kind of thing.

The training she was getting as an occupational therapy student at her university during that time augmented her familiarity with using crafts as a day camp counselor. She says:

> [K] Ah, you know I enjoyed all the crafts we did – we did a lot of crafts. We had to learn leatherwork and woodwork and weaving and basketry and pottery and sewing. I enjoyed that.

At the time, it didn't occur to her that the play activities she was familiar with from her camp days and had enjoyed during her occupational therapy classes

might not be familiar and/or interesting to the children with whom she was working. Looking backward, she is aware of how differently she might have thought about the children and activities, and how differently she might have gone about these "daily activity programmes."

The occupational therapist with whom Katherine and her classmate were working in that practice landscape had developed therapy activities for the adult First Nations women there that involved activities familiar to the clients, such as making mukluks and mittens. Katherine was able to participate in doing some of these activities:

> [K] There were native women there who were in a similar situation and [her supervisor] had created some really culturally appropriate programs for them. They made mukluks and boots and felt liners and embroidered them. They taught me to embroider, sew together some felt mittens and, you know, the smoked moose-hide. You either love it or you hate it. It's really strong smelling and I got to really like it.

Katherine's OT supervisor had made an effort to learn more about what activities her First Nations clients would have had some experience with in their lives in the North. The clients taught Katherine new skills from their experiences, and she discovered new materials like smoked moose-hide, which she came to appreciate. She realizes now that these women:

> [K] They could have even come in and done some games with the kids; it would have been very easy. They could have come and done some games with the kids.

It occurs to Katherine now that it would have probably have been very possible for the adults to play with the children, bringing what they knew from their own childhood experiences, or their experiences with their own or others' children. But she didn't think to ask the women to do this.

The background I came from did not prepare me to understand their worlds

Of her experience in this place, Katherine reflects:

> [K] One of the things that I came away with from that was the feeling that in order to do occupational therapy with the adults there, that I wouldn't have been able to, without visiting or seeing where they lived. That I knew the background I came from did not prepare me to understand their world. That has stuck through into my medical-legal consulting. I always say I have to see the person in their own setting. Even if that means a lot of travel. It's probably even more important for the ones that mean the most travel, because they might be in the environments that have a whole lot of things I would have made assumptions about and been so wrong, so totally out to lunch.

Looking backward, she realized that in order to be able to have something to offer to clients as an occupational therapist, she had to know more about her clients' everyday contexts. Continuing to reflect on this early place where she was a student, Katherine says of her own lack of knowledge about the clients there:

> [K] I mean, you've got the little OT kitchen. You don't even know if they have a stove, what kinds of foods they need to prepare, how they would typically prepare them, how they would have got them.

As I inquire into this story of daily activity programmes in this specific place and time, I think about other stories Katherine shared over the course of this inquiry. Looking forward from this early experience as an occupational therapy student, it seems clear that what she learned from this experience has powerfully affected her practice throughout her career. She talks about how it has shaped how she did medical-legal practice – she insisted on seeing people in their own contexts rather than doing all of her assessments in a clinical environment.

Nice presentable young ladies

Katherine was educated as an occupational therapist at a large Canadian university during the mid to late 1960's. At that time, on that campus, there was considerable political unrest, with students occupying departmental offices and becoming involved in large-scale campus demonstrations. Katherine recalls that this unrest did not touch her faculty, even though she was aware of it:

> [K] … They were into these big political battles. We were just a couple of decades behind in our faculty, I think.

A proud achievement she remembers is being on the Student Council and, as President:

> [K] Our big accomplishment of the year was that we got the faculty to agree that we could wear slacks. And that really WAS a major accomplishment. Because before, we were supposed to be nice presentable young ladies and [sigh] young ladies don't wear slacks and certainly not jeans. Jeans were never, we never even asked about jeans.
> [S] That wouldn't even have been on the map.
> [K] But it meant, you know, in the middle of winter we were tromping around with, you know, if you wore something extra, you had to take it off to come into class.
> It was just crazy, it was stupid! And anywhere else on campus people were wearing slacks. So you know, that gave me a lot of confidence for other things - getting that accomplished.

Taking on a leadership role, she was able to contest dress code rules that she saw as illogical and unfair. Being successful in getting this rule changed gave her assurance in taking on other issues. Looking backward, she tells a story of school that is about, on one hand, a campus full of protests, and on the other, more immediately, a story of rules, regulations and living out a story of

being a presentable young lady. She tells another similar story of rules and regulations. When doing a fieldwork placement in adolescent psychiatry in the final year of her undergraduate education, she called back to her university programme to ask if she could play baseball with the clients wearing something other than her white student uniform:

> [K] I phoned the university to see, did I have to wear my white uniform and white shoes, because on that unit nobody wore uniforms, and the answer was, yes I had to. [Laughing] My programme was so stuck in the mud.
> [S] Reminds me of my mother's nursing education stories.
> [K] I should just not have mentioned it and gone ahead and worn street clothes. The risk at that time would have been that you could have gotten into really serious trouble for doing something like that.
> [S] So here you are playing baseball in your whites…?
> [K] Yes, here I was playing baseball in my white dress.

She was told by whoever she talked to at the university that:

> [K][DP1] "You are an [X] University student, with your [X] uniform, upholding the [X] name. You are *Miss* M."

What I notice as I inquire into these stories of Katherine's professional education by looking outward is how much she was being inundated by messages coming from the conduit. She was being told how she should dress, what being professional meant, and the importance of upholding the honour of her university. She was being told to follow the rules, even when the rules were "crazy, "stupid" and didn't make sense to her. As she says of herself:

> [K] I don't like the thought that other people can tell me what to do. I mean, I'm willing to go along with it when it's also what I want to do, because you get some resources you wouldn't otherwise. But it comes to a point where I really don't want to do that or I think it's stupid, I don't have much patience to do things I think are meaningless or not going somewhere, were not going to be useful.

Katherine's stories to live by are about looking closely at rules and regulations, and deciding when it made sense to follow them, and when it did not. It isn't surprising then that she would contest some of what the rules of her university programme were telling her she should do. These somewhat mis-educative experiences happened both in classroom and clinical settings. One of the useful things that Katherine remembers from her courses, in addition to crafts instruction, was getting to role-play in a mental health class. As she says:

> [K] I enjoyed the mental health stuff – the classes there were a huge revelation to me. I still remember watching and participating in different role-plays and being absolutely amazed and freed by how much I could be a totally different person– like quite a nasty person – I could just be, quite easily. I was blown away at how easy it was to be totally different, by just by being given permission to play a different role and be, you know, a really nasty person. It was startling! [Laughs]

In some way, was this a chance for her to learn more about being able to travel between her landscapes and those of others; to get beyond being one of the "nice presentable young ladies"? I think about her realization as a student that she needed to know more about her clients from the north. I wonder if this is one reason why these long-ago role-plays were so memorable? Did she feel stuck in a programme that she saw as a couple of decades behind the rest of campus, stuck in the mud, but in this one course when she was involved in role play, could she perhaps 'world' travel (Lugones, 1987)?

I wonder, too, if wearing her white uniform and her white shoes made it difficult for Katherine to enter into other worlds. Certainly she would have

been an odd sight on the baseball field and in the hospital gymnasium. Looking outward onto the professional knowledge landscape of that, and this, time, white uniforms were, and are, part of professional identity, of establishing that the person wearing whites is in a position of authority. In this position of authority, perhaps it is hard to recognize other's positions? I wonder if donning the white uniform, introducing herself as Miss M from the University X, sometimes meant she put on a kind of "arrogant perception" (Lugones, 1987). Perhaps this is what happened in that distant hospital with the First Nations children with whom she was working? Maybe she couldn't see how what she knew about play, and what they knew about play, might be worlds apart. She realizes now, many years later, that she never thought to ask about what games these children would have played, or asked the women she worked with to join in these daily activity programmes. She realizes how separate she and her student colleague were from the people they were working with. She talks about how insulated she was in this healthcare landscape and in her school landscape.

What is it you need to do in your universe?

In one of the research meetings, Katherine described her awareness of the parallel universes that therapists and clients inhabit, and the importance of trying to understand her clients' worlds:

> [K][DP1] You just get this sense that there are zillions of parallel universes – that this is really, really different than my universe. These people like mud bogging as a hobby… sled-dog-racing …
> It's another world. It's, again, another whole world, and it's right in this province and you'd never even know it existed. What I've loved about

> OT is all these opportunities to keep stepping into these other worlds, and there's zillions of them, all these other worlds. And I guess what you come out with is realizing that the worlds that you think are pretty similar to the worlds you're familiar with, they aren't – they're all different. Everyone has their own somewhat unique parallel universe, with their own family dynamics, and what they've brought with them in terms of background. And that's the OT's job, to be able to step from one parallel universe into another and try to understand it. And say, what is it you need to do in your universe, which is not my universe… and do I know enough?

In her practice, Katherine encountered people with many occupations and environments that were unfamiliar to her. As a student she had been unaware of her northern clients' worlds, and somewhat separated from her clients and team as she played baseball wearing her white uniform. Taking what she learned from that experience, the importance of seeing people in their worlds, has meant that Katherine has become very aware that her world is not the world her clients inhabit. She sees being able to enter those worlds – what Lugones (1987) has described as 'world' travelling – as a crucial part of what occupational therapists do.

Katherine had the opportunity to explore so many diverse worlds as an OT, places where people are mud-bogging and sled dog racing and making mukluks, and looks back on this as one of the reasons she loved being an OT. Being aware that her experiences and contexts were very different than those of her clients, she decided that one of her roles as an OT was to learn as much as she could about her clients' situations. She needed to "know enough" about what they did in their lives and about their stories to live by from growing up in their families. This was something she could do better by seeing people in their worlds rather than only within hospital walls.

Katherine spent a considerable amount of her career working in home care. She talked about what she enjoyed about that work:

> [K] I loved home care. It was so real! You go in and you find out what it is that people want to be able to do and what they can't do. And figure out how you're going to help them to do what they want to, which might include – 'Let's see, how are you going to get into this car until this leg heals, what if you got in on the other side, or could you sit in the back, or let's go out to your car and try it out? OK – if you put a cushion in here …' so it was lots of problem solving and lots of dealing with family members.

Working in home care, she felt that she was seeing the person in their real contexts, seeing what they needed and wanted to be able to do in those landscapes. Once she had a sense of that, she collaborated in problem solving with clients and family members to see what would work in what she calls those parallel universes.

Katherine told the story of working with a client later in her career, and making a three day trek by air and truck to a remote northern community with the lawyer she was working for, in order to see the client's home and community, something she says was extremely useful [DP1]. What she learned in that early place about needing to know much more about her clients' worlds in order to be able to help them became part of her personal practical knowledge of how to be effective as an occupational therapist. The importance of understanding others is also one of her stories to live by from childhood.

You need to be kind and understand other people

When I asked Katherine about what she'd learned growing up in her family, she told me:

> [K] I feel really blessed because I had a loving family, a functional family, not a dysfunctional family and I've always felt really fortunate because that's luck; you don't get to control that. And that has been a powerful foundation for me. So some of the stories – I think of my mother and her saying to me you need to be kind and understand other people. And she would maybe get frustrated about things in her life, but she'd understand. She'd talk about why other people might be doing things. That there might be a reason someone might act a certain way.

Katherine had the good fortune to grow up in a loving and functional family. That experience has provided her with a stable base for living her life. As a child, she spent time with a family member with a progressive neurological condition. She recalls that:

> [K] He was really homebound. He got out a bit but he didn't have much to do in those days. And then watching him go into hospital and realizing just how much more limited his life was, how important it was to have some connections…

Her family member became more and more isolated, and had less and less chance to engage in activities. She says that it was her experiences with this family member that influenced her choice of a career in rehabilitation.

Katherine learned from her mother that it was important to be both understanding and kind. This story to live by helped her suspend her own judgments of people, looking instead to understand why someone might be acting or reacting in a way that she wouldn't have anticipated. Perhaps it is

this kindness and willingness to try to understand that helped her to be aware of these "parallel universes" that she then learned to step in and out of during her practice.

During the time Katherine was working in home care, she found that being in someone's home made a difference in being able to understand, being able to see why certain things might be the way they were. She stepped away from being more distant in her professional approach to be able to both literally and figuratively enter into her clients' worlds:

> [K] You know when you're in someone's home – you're their guest. So a lot of the barriers that are there in the hospital in terms of, being an important big professional person, me being a little family member, or patient, I'm not sure what I can ask - those are just gone. You're just starting from so much healthier a place. So much more constructive a place. I find you can start up a relationship so much more effectively and people know you're there because you really want to do something to help them. You've come to them. You care enough to be there.

As a guest, she felt she was able to have better, healthier relationships with her clients than when she was in a hospital setting and wearing the metaphorical white uniform of professionalism that placed her above her clients. In becoming and being a guest, perhaps Katherine was able to move from "arrogant perception" to "loving perception" where, as Frye (in Lugones, 1987, p. 8) says, "to know the seen, one must consult something other than one's own will and interests and fears and imaginations." By her being there, she was able to demonstrate that she wanted to help, that she cared about her clients and their families. In this practice landscape, she was

better able to live out a story she learned from her mother of kindness and understanding.

Any institution tends to put up walls around itself

Looking forward from this early story and outward to the institutional rules she encountered later in her career when she was a Director in a large rehabilitation facility, Katherine reflected on the limitations there that made it difficult for occupational therapists to be able to see clients in their own worlds and to assist them with what was most important to them:

> [K] Any institution tends to put up walls around itself. I think it's just the way they are, the way they grow. There wasn't the freedom for OTs to just go out. This is the thing I've always wanted to do, I always knew that I want to know is what the home environment is, the basic culture. Well there wasn't funding to do OT outside the building; that was homecare. So if the OTs wanted to go, to be working on something with a client, they could do driving transfers and stuff in the car and that kind of thing. But they really weren't going out of the building whenever they wanted to. There'd be a home visit just before you go home. But there really wasn't much going outside the institution and there wasn't time and there wasn't funding and it wasn't really supported by all the other institutional forces.

In this rehabilitation place, therapists were constrained in their ability to physically travel to where their clients were, or would be, living. They could get as far as a car outside the building, but beyond that, they almost always passed their clients on to home care staff. Funding and institutional policies dictated that occupational therapists mostly stayed within the walls of the institution. For Katherine, this created a bumping up place where her own experiences of working in home care and being able to be a caring guest were in tension with the policies that she was supposed to endorse.

As a Director in this setting, Katherine found her days swallowed up in meetings and paperwork, and, after four years, decided she was not willing to continue working there. What she is most proud of from her time at this rehabilitation place was that she was involved in making the sexual health programme at the facility better known to clients:

> [K] The discussion about sexuality that might come up over transfers or dressing or something, 'oh gee, I don't look very attractive anymore, I don't know what my partner… I'll never get a girlfriend again'. Things that come up that aren't being dealt with along with the other stuff because people are not comfortable bringing it up on their own. One of the other things I worked really hard on – they had a sexual health program going. They had it in little room in the bowels, almost literally, of the hospital. You had to walk a long corridor and you'd get to the little closet at the end. That was Sexual Health… It was embarrassing to go there. It said, 'This is something we don't really want to talk about.' I spent the whole time there and I did finally make some headway bringing that program out to more prominence, getting pamphlets printed so all the patients got informed that there was a programme, that it was free, that was for them, that was confidential, that they didn't need a doctor's referral. You could just phone and say 'Can I come talk to someone?'

Katherine realized that some of the occupational therapists were having these conversations with clients about sexuality, that arose from what they were doing in the role dictated by the physicians in that place, which was that occupational therapists should focus on assessing and working on clients' activities of daily living (ADLs) abilities:

> [K] Can the person dress themselves, feed themselves, do their own hygiene? And of course those are important, but that was all that they wanted. And they did not want anything more, the broader role of OT, of what was meaningful, and where are they going to be going, and it just wasn't something they wanted.

In the course of working with an occupational therapist on ADLs, clients might express deep concerns about their attractiveness, their ability to have

relationships, to be sexual. The rehabilitation centre had not completely ignored these issues and the Sexual Health Service had a couple of occupational therapists, but clients had to navigate into an almost hidden world to find someone who could help them. Katherine was able to see that these clients needed both information and encouragement to be able to seek out this world nested within the world of the rehabilitation centre. She talks frequently about the "underground practice" (Mattingly and Fleming, 1994) that occupational therapists often do. I wonder if one of these underground practices is around helping clients to talk about sexual concerns. Katherine's ability to hear what therapists were telling her about the conversations they were having with their clients concerning what clients needed, and wanted to do in their universes, helped her identify just how hidden the Sexual Health Service office was for clients. Her response was to use her status as Director to contest the unspoken messages that clients were getting about whether their sexual concerns were something that centre staff were truly willing to have a frank discussion about. Here again, Katherine was realizing that 'world' travelling was essential. In this case she travelled in her imagination to see just how inaccessible the so-called service was to clients and tried to find a way to make it less so. She was again trying to understand others' worlds, to use what she had learned as a student who hadn't been able to step into the parallel universes of her young Northern clients.

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Working on work: in the community

This narrative account moves forward from one of Katherine's stories lived as a student. It moves past her first job working in a large general hospital in mental health, which she enjoyed and briefly, unsatisfyingly, on the spinal cord unit, to a job in the community:

> [K] So there was a phone call to our department, someone was looking for an OT who was interested in working for another organization that they wouldn't name and that was outside a hospital, and that really intrigued me. My ears picked up.
> So I went off to this interview not knowing who the organization was. Because it was a headhunter and you know, if they told you who it was, then you could go directly there and they wouldn't get their fee. And it was a not for profit organization. They'd hired a psychologist and she wanted an OT on the team, which was quite advanced I think, and she had had no luck trying to find OTs. So she had gone to a headhunter. So anyway, I went off for this interview and finally got to find out who it was. Because at this time, there were no other places – people, OTs only worked in hospitals. OTs didn't work in any other places.

In her first job Katherine had enjoyed working with clients with psychosis, depression, or personality disorders that brought them into hospital as inpatients:

> [K] So we did all kinds of crafts – we did a lot of rug hooking and we'd make up our own patterns, we did some sewing, we did leatherwork, we did pottery, weaving – it was very much the old school. We did lots of finger-painting and other painting, lots of projective stuff. The head OT had some wonderful things she'd do with people, projective techniques, painting and get them to draw out their life story, or sculpt it or make clay figurines and get them to draw out their life story. It was so interesting; I just really, really enjoyed it.
> [K] You know people laugh about OT's doing basketry, but actually basketry has so many useful different little components about it. I used it a lot when I worked at my first job, because sometimes people who couldn't concentrate on anything else could concentrate on something like that. It has nice, repetitive parts to it. You can see

> where you were and you could fix it if things got a little wacky, just go back a few steps, get that little missing piece put back in there.

Working with clients with mental health concerns, she had the opportunity to use some of the craft activities she knew from childhood, she had studied while an OT student, and had experienced while on fieldwork. As well she was able to learn from a skilled occupational therapist about how to use art as a means of understanding clients' life stories. She discovered the value of a variety of crafts – the usefulness of something that was repetitive, that could be undone, and fixed, when things started to go wrong.

She'd been less happy working briefly on the spinal cord unit:

> [K] And I hated going to work. That was one of the periods when I remember hating walking across the parking lot to the hospital, dreading it. Just thinking, "I really don't want to do this." Feeling, "I don't really know what I'm doing. I feel totally incompetent with people who were very dependent." Pretty scary! So that was a negative experience for me – the patients weren't. Just that I felt like I wasn't prepared enough.

Katherine had moved from inpatient mental health to the spinal cord unit in the same hospital, hoping to gain new skills. Lacking a mentor, she found that she didn't know if she was doing things correctly, and was worried about whether her lack of experience might hurt her clients. It was one of only two times in her occupational therapy career when she really didn't like going to work.

I wasn't sure if that meant I was leaving the profession

So when this phone call came to the OT Department, Katherine was very curious. Who might be looking for an OT to work outside the hospital; did

OTs even work outside hospitals? After her early experiences as a student, and what she learned about needing to know people in their worlds, she says:

> [K] I really liked the idea of being out in the community and outside the hospital. I think that goes all the way back to the time at the place where I was a student with the kids from the north – thinking, so how can you help people if you don't know anything about their world?

She went for an interview with the organization, which was a not-for-profit group that offered vocational training programmes for persons with disabilities:

> [K] And I got the job. And at the time I wasn't sure if that meant I was leaving the profession. Because, it was outside of the hospital I didn't know if other OT's would think I was no longer an OT. I felt like it was OT and that they were looking for an OT, but the job wasn't called OT - it was called work evaluator.

In this out-of-hospital place, she saw that she could practice as an OT, even though she wouldn't be called an occupational therapist. She saw the possibilities for working with people in a more real-life environment. Katherine was anxious about whether her peers would think she had left the profession by taking this job. As I inquire into this story I wonder what was it that made it possible for her to make this move to another practice landscape? What stories to live by did she have of being a pioneer?

It's okay to pull up stakes and go somewhere, do something entirely new

Katherine told me about a book that her sister had been working on about their mother. As she read the final draft of the book, she had realized:

> [K] And it made me realize in our family, that it goes back a long way, that people made these long journeys back and forth across the country,

> and changed where they lived. Right from coming from the old country, coming to Canada, and coming out West and my mother going East and me coming out West. And now my younger daughter is going East. It's part of our family's tradition that it's okay to pull up stakes and go somewhere and do something entirely new. And it's usually worked out.

While she might not have been able to articulate it at the time she was making this decision to "pull up stakes", Katherine had a familial story to live by of being able to make these big moves, take chances on doing something completely different, and have things work out most of the time. She was leaving the familiar place of hospital for a new landscape, doing something that was similar but different to what she had done before, and this familial story to live by helped her do that. Looking backward to her story of travelling across Canada to do fieldwork, I hear her saying:

> [K] I didn't want to stay at home; I wanted to have my adventures.

Looking forward from this story to others Katherine told, I see again this confidence to be a pioneer, to try new places, and to do new things. Her career has included being a partner in a group that set up the first private homecare practice company in her province, being the first OT at one university to complete a Master's degree in occupational therapy, and being one of the first OTs in her province to go into medical-legal work.

All those jobs - I got to do all sorts of things

In her new job as a work evaluator in this new landscape, Katherine was responsible for helping clients gain work skills, social skills, and a work history so they could move from sheltered to competitive employment, if possible. The organization used a wide variety of tasks to assess abilities and

to help clients gain skills and confidence. Katherine made a point of trying out all of the work tasks and areas so she had first-hand experience of what was involved:

> [K] So I'd do all those jobs - I got to do all sorts of things. And set the standard for the time to do a certain amount. So that would be a baseline based on me. And I know I'm faster than average with fine manual dexterity. So I always say to people, you should always test yourself, so if you're faster than average you are not expecting other people to be doing it as fast as you can, because that's not average. So maybe you're expecting too much. So again you need to know yourself, what's easy for you might be quite hard for other people. I'd sort of say, 'this is my score, so I'll set the baseline somewhere a little lower than that.'

Katherine did each of these tasks so she could understand what it was like to do each one. In addition to knowledge of how she would do the tasks, she also thought about how her ways of doing them might not be how others would, or could, do them. Is this another example of her work as an OT being informed by one of her stories to live by from her mother – of the importance of understanding and being kind? In knowing herself – knowing that her fine motor skills were above average – she could understand that some people would not be able to complete the same amount or quality of work as she could. This helped her to both be kind to the clients she worked with in this place, and to remind the students she taught much later that they needed to be self-aware and to consider how they set expectations.

As I inquire into Katherine's story in this practice landscape, I think about kindness and understanding and how these qualities are nested in the concept of *empathy*. Healthcare professionals are encouraged to develop the

skills needed to be empathetic. Peloquin (1995) talks about empathy in occupational therapy practice. She describes the unique opportunities that occupational therapists have to not only *be with* but also *do with* when working with clients. She further notes that occupational therapists bring not only them*selves* but the "trappings of occupation: objects, tools and activities (p. 29)" to the work they do with their clients. In order for Katherine to be able to have a sense of what she was asking clients to do, she did all of the tasks, learned about the objects, tools and activities in that place that clients might be assigned to do. She thought about how to fairly compare her performance to others. She lived out her story to live by, of understanding and being kind.

They're still so far from real life

In this practice landscape, Katherine had the opportunity to try out some expensive work simulation tools:

> [K] We had some work samples, Valpar workstations – they were never really that useful. We thought they might be useful to evaluate what kinds of abilities people might have and potential. But you know the problem with all those simulated things is that they're still so far from real life. It's really, really hard to simulate things! And then the issues that people fail on are not usually the issues, the things you're doing in the simulation. It's the social stuff, that they're able to adapt to change, being stable day-to-day …
> [S] The simulation is not very stimulating.
> [K] It's really hard to make them really, really realistic. So they just took up space.

These workstations simulated aspects of job tasks, and could be used to assess speed, accuracy and other aspects of working. But what Katherine found was that the simulation was not realistic enough, and that ultimately it

wasn't the specific job tasks that were the issue as much as individual resiliency and social skills. She had seen real tasks used in the agency in which she was working, and at her first work place in psychiatry in the hospital, where:

> [K] There was a full kitchen in there. It made it a kind of safe place for people to come when they were ill, where they were doing things that were familiar to them and that they were going to have to resume doing. And it helped them restructure themselves and, you know, gave us a chance to evaluate how they were thinking and whether they were capable of doing those activities or how much help they needed.

In that practice place, Katherine saw how the opportunity that clients had to do things they'd done before, in an environment that, for some, was similar to one they might know, provided a safe place. In that protected place, the occupational therapists could also get a sense of what clients might be capable of, or need help with. Looking even further backward to her experiences as a student completing fieldwork at a facility for injured workers, Katherine identified a strength of occupational therapy in that practice landscape as being that:

> [K] I think in terms of using occupation, there was very much a focus on doing things that produced things. You know, doing activities so that you were making a box or a shelf or a bookcase or you were sanding a breadboard or, you know, the work always, or almost always, had a functional and productive kind of output. Now I think the part that was still missing for some people was that those activities weren't that relevant to where they wanted to be, but it was more than just, you know, [sighs] taking clothes pegs and moving them from A to B and back.

The clients in that place were able to work with real tools and real projects that were, for some but not all, relevant either to the work they were returning to, or a recreational interest they had. Clients weren't being asked

to do what Fisher (1998) might refer to as contrived exercises like moving clothes-pegs between two points.

Katherine had personal practical knowledge of the value of using real rather than simulated work from being a student, and from her first job. That didn't mean that she wasn't willing to try out the new equipment, but it did mean that she was not so smitten with this high-tech addition that she changed her practice. These questions of real versus simulated work that she first started exploring in this community setting followed her through her career. Her graduate research compared real-world tasks with simulations of those tasks at different intensity levels. As she says:

> [K] So there were three work intensities of real tasks… and then three on the equipment that were comparable. So it's still the issue of "How close is real life to some sort of simulation?" Not close. Useful, but not close.
> [S] We've had some of these discussions before about simulation.
> [K] It' s just extraordinarily hard to find things that are really like real life.
> [K][DP1] It's supposed to simulate real life and the question was, does it? And my answer was – not really. Life's way more complicated. Not that it couldn't be useful… it's just not real life…

Looking forward, Katherine's personal practical knowledge of using real versus simulated work gained from working at the community agency, and her research comparing real and simulated work, bumped up against institutional narratives of being "high tech" when she later worked as a Director at a rehabilitation faculty. In that place, they had purchased and installed an expensive system that was supposed to be able to simulate a wide variety of daily tasks like dining out, grocery shopping and banking. This system had been purchased before she arrived. Centre administration

wanted the place to be well used, so the people who had raised funds for it would feel it had been a worthwhile contribution, thus occupational therapists often took clients to the area when the media were there to show the equipment was being used, when, in fact, most therapists were not using it on a day-to-day basis.

The OT community still thought I was an OT

During the time Katherine was working in this non-hospital place, what was happening in the professional practice landscape? This was an era of increased interest in work evaluation and "work hardening" both inside and outside of the occupational therapy profession (Hanson and Walker, 1992). Testing equipment like the modules that Katherine had access to in this place were being developed and promoted heavily, and occupational therapists were being encouraged to show how their unique combination of knowledge and skills differentiated them from vocational rehabilitation counsellors and others (Holmes, 1985). Within the professional practice landscape, Katherine was, perhaps, being storied as someone who would proudly plant the flag of occupational therapy and reclaim territory that had been lost. Given her stories to live by of travelling to new places and that "it's usually worked out", she carefully explored this place, and negotiated ways to use her personal practical knowledge to do what she thought was most effective for the clients, to carefully look at what she knew about real and simulated work. Although Katherine had to negotiate the tensions in that practice landscape, she enjoyed working there. She says:

> [K] I did get the feeling that the OT community still thought I was an OT after awhile. I didn't know if they would, but they did still see me as an OT.

They went on and left us and that was the goal of the whole thing

Katherine says that the agency helped people enter the workforce:

> [K] In fact a lot of those people did make it – there were a bunch who were able to get full paid employment.

The agency had been operating as a sheltered workshop for many years. The expectation at that time was that many clients wouldn't be able to work outside a sheltered environment. Katherine tells a story about looking at client files:

> [K] I got to look through their old files. Some had been there 20 years. And there were no years on a lot of those things. So from there I got to 'You always date absolutely everything including the year; you put the full date, always, always, always.' Because I'd get reports like 'Marie is doing much better now, her temper is much better, she's getting along with other people and she's becoming quite productive.' And I didn't know if that was 10 years ago or this year.

She recognized from that experience how important it was to document client progress and communicate clearly when that progress was noticed.

> [K] I think you just have to be really careful that people don't hang around who don't need to hang around.

Katherine was again looking carefully at the rules, regulations, and procedures that she found in that place, and considered how they affected clients. Just as she had questioned the need to wear a dress to class when she was at university, or her white uniform to play baseball when on fieldwork, she thought about how some the agency's rules and practices might be keeping clients from moving into the world of competitive employment. And

she created changes in how the agency worked that helped highlight client's progress towards being able to enter "real" workplaces.

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Making coffee

Another story of *doing occupation* that Katherine shared was from an experience she had when she first started working in a medical-legal practice. In medical-legal practice landscapes, the primary role of the occupational therapist is to assess the functional abilities and need for support, of clients who have been injured in an accident, and who are involved in litigation subsequent to that incident. Occasionally other cases involving malpractice, contesting the employability determination done by an insurance company, or a divorce case where the question would be about an ex-spouse's earning potential, could also be part of medical-legal practice. Typically the therapist will complete an extensive interview with the client, as well as assessing functional abilities related to self-care, work and leisure. Usually the therapist will see the person within their home and/or work environments, as well as in a clinic setting for testing. Depending on the practice and the therapist, a variety of standardized assessment tools may be used, along with observation of the client's performance in a variety of tasks. The therapist is contracted by a lawyer, and may be acting on behalf of either the plaintiff or the defendant. In the practice landscape in which this story took place, Katherine was working in an institutional setting, but one in which she had considerable autonomy to manage her own work and decide

what she needed to do with any one client. This is a story from that practice place.

And he didn't know

> [K] I remember working with a fellow who had been in a serious car accident. He was nearly killed – he had an impact to his chest that was very severe. But when I saw him he had been living in a relationship that was a very co-dependent relationship and not very helpful for either party I don't think, certainly not for him.
> Because I'd ask him things like, 'Could you pick things up from the floor?' And he didn't know. 'How about if I put this Kleenex box on the floor and you see if you can pick it up?' And he'd be able to do it. But you know he was being totally taken care of; he was being dressed by his partner. And when I got then into the testing part of the evaluation and I was asking him to lift weights at various height levels and he'd say 'Well I haven't done this before' and I'd say, 'Oh well, what do you think; do you think you can do it? Are you interested in trying or do you think you can try? What would happen if you try? It's your choice, you don't have to do any of this. I want you to be sure you let me know if any of this is too uncomfortable or painful – you can stop at any time. Do you want to try it?' And he'd try it. And he was doing way more than he thought he could – way more.

This seriously injured client had been referred for testing by his lawyer. As part of her initial interview with the client, Katherine started to explore what the client was capable of doing physically. She asked him to attempt a very light task like picking up a box of tissues from the floor. She noticed that it seemed he had no sense of what he could, or couldn't, do. As part of her initial interview with him, she found out that his wife had been doing everything for him, including dressing him. During the lifting tests, Katherine continued to ask the client about what he thought his capabilities were. He continued to be unsure, and, although Katherine repeatedly told him he could

stop at any time if he was feeling discomfort, he continued to do whatever lifting task she asked him to do.

Pay attention to your own feelings

> [K] I remember when I was a student being taught that you had to pay attention to your own feelings, you had to say 'Hmm, how do I feel about what's just happened here?' And what I said to him was 'I'm getting a little scared because I feel like you're getting a little angry with me. Because every step through this lifting test, I say, 'You did that, could you do more? Could you do the next level?' And he could never say no and he'd do it, but he'd be angry. I was thinking – 'At some point this man is going to explode. Let's talk about this.' I said, ' I'm beginning to feel a little nervous that you're getting really angry and I'm asking you if you want to go on, but you're never saying no', and that was when he started talking about how he couldn't say no, didn't know how to say no, especially to a nice lady [laughs].

As the testing proceeded, Katherine paid close attention to what she was feeling, and noticed that she was feeling somewhat frightened. She wondered if this client was feeling angry with her for asking him to do ever more challenging lifting tasks. She asked him if he was angry, and told him why she thought he might be angry. That's when he told her that he had difficulty saying "no" to nice ladies. It was out of this discussion that she learned about his situation at home:

> [K] This is when he started telling me about his relationship with his wife who he married because she had moved into his apartment on him and he hadn't felt brave enough to tell her he didn't want her there. He was a good Catholic and he didn't really like to be living in sin, so they got married. He had never really wanted to do any of these things. But he was a very polite fellow and he'd left home at 12, he'd been on his own since he was 12. So he just had no experience with what a relationship should be or how you should conduct yourself or that you can have some control over your decisions. Just because a woman moves in, he could've said, 'No, you can't move in with me' but he'd never felt able to make those decisions.

Influenced by his early upbringing and his religious beliefs, he had no experience in identifying and asserting his own needs in a relationship.

As I think about Katherine tuning into her feelings, and through doing so, opening up an opportunity to learn something extremely important regarding her client's stories to live by about interactions with women, I wonder about *therapeutic use of self* (Mosey, 1986). A skill that occupational therapists are encouraged to learn, *therapeutic use of self, is* described as consciously utilizing one's own responses to clients within therapy. Taylor's (2008) exploration of therapeutic use of self by occupational therapists led to the development of the intentional relationship model. This model suggests that skilled therapists use interpersonal skills, the ability to switch *modes* (between advocating, collaborating, empathizing, encouraging, instructing, problem-solving) and the ability to reason through interpersonal dilemmas that occur in the course of therapy. Looking at Katherine's responses to the client, it seems to me that she was able to shift from *empathizing* mode, to *encouraging* mode, in which therapists work to find ways to help clients regain hope, and *collaborating* mode (communicating the need for the client to be an active participant in therapy).

There are healing forces in the world but you have to touch them

As Katherine learned more through hearing the client's stories, and by beginning to assess his physical abilities, she started to understand more about this client's stories to live by. She began to recognize what she might be able to help him with during the assessment process:

> [K] Because this was the fundamental underpinning of his whole rehabilitation. He really needed to feel he could make change for himself. That it was okay to try, that was safe to try, that he was in control of his life and we had a little chat. I asked, 'Do you want to go make coffee while I'm writing stuff up? Do you want to go put the kettle on and we can have some instant coffee?' Which was quite nice in the testing area in that place because you could do that. And he had never done that. I said, 'Well do you think you can?' He thought he could, so he went and made coffee. Well that was again a first for him. And I said to him, 'There are healing forces in the world but you have to touch them and when you're making coffee and when you're touching the kettle and you're touching the cups and you're touching the water, you're touching a healing force.' [Tears up] And that was, he was a native fellow, I though that was something that wouldn't tie into any of the negative stuff in his Catholic background and it's actually something I believe.

In attending to her feelings, and sharing them with her client, she learned something that became her focus for the remaining time she spent with this client – helping him to understand that he could be in control of his life, that *doing* wasn't inherently unsafe, that change was possible. And she asked him to *do* – to make coffee for himself and for her, to take on the role of a host within that clinic place. And, perhaps because he'd been asked to do it by a "nice lady", he tried something he hadn't done before. In that moment when he returned with two cups of coffee, she told him what she believed about how he would recover from this horrific injury, that by engaging, by touching the kettle and the cups and the water, he was connecting with a healing force. Because she was aware that he had negative associations from his childhood about specific religious beliefs, she tried to steer clear of making comments that were clearly religious, but chose instead to try to communicate a spiritual message about healing. As she tells this story, and she told it to me

both in our initial discussion and during a research group meeting, her eyes welled with tears and her voice cracked.

Following along from this event with this client, she said that:

> [K] So he had to come back because we didn't get through all the testing we needed to do because we were talking. But he came the next time. I think there was a delay of about a week. He came in bursting with pride to tell me that he had taken out the garbage, which wouldn't have meant much to anybody else, but this was something that, it isn't something he would've even have thought of doing before. But it was engaging again; it was him touching the world and engaging with life.

One of the things Katherine said she appreciated about her medical-legal work is that she had the time to meet with clients multiple times to learn about their stories and to complete whatever assessment seemed indicated. She was able to see this client again, and to hear about his success in completing another everyday task – taking out the garbage – and to celebrate that with him. To her, this was a sign that her client had begun to engage in daily life and begun to heal.

As I inquire into this rich and multi-hued story, I too feel tears welling up. I wonder about what past experiences had brought Katherine to that point, where she was able to so clearly hear what had been left unsaid, to be able to set the client to doing a mundane task, and to frame it so powerfully to him as a spiritual act. I wonder about why what she said had such an impact, and about her celebrating with her client this small next step of which he was so proud.

If you don't understand where all that is coming from, you're never going to fix it

Looking backward, I am drawn again to Katherine's stories to live by that came from her mother. With her client, she was taking the time to understand why this injury had been even more debilitating than anticipated for this individual:

> [K] It just absolutely blew me away that someone could be so naïve about themselves, about their body and so unable to stand up for themselves and really so unaware that what he was doing was so harmful to him, but he really was naïve. I bet you, in some insurance settings, they would say, 'This is a guy who's capable of doing all sorts of things and isn't doing it. Malingering.' They would've cast a really negative light on that and they would have thought, 'Well there was no reason he couldn't do certain things', and they would have been right. Well, there was a reason, but there was no physical reason he couldn't. I mean, he was still having pain from this massive wound to his chest which nearly hit his heart and almost killed him and which was scaring him still. I mean that was a close call. So he had all sorts of anxieties about that. But if you don't understand where all that is coming from you're never going to fix it. And you can call him all sorts of names and you're not going to fix anything.

Katherine was initially taken aback by how unaware about himself she found her client to be, how passive, and how unable to advocate for himself. Katherine thought about how he would be storied, the names he would be given, by the defence side in this lawsuit. She reached back to her own stories to live by from her mother, to her education and experiences in mental health, and what she knew about the client's stories to live by, and, in this, was able to understand and be kind. I think again of Peloquin's description of acts of empathy that require occupational therapists to be (1) present in the moment, (2) attuned at a deep level to their client, (3) able to recognize

similarities and differences between themselves and the clients, (4) willing to connect with their client's feelings, (5) able to recover from that connection, and (6) learn from these experiences (p. 29). In this story Katherine was very much present with her client, and had explored his background enough to have a sense of her client's life experiences, and how his experiences and hers were both different and the same. She used her emotional responses to tune into what her client might be feeling. As she recovered from that connection, she changed her plan for the session, rather than simply continuing on with testing. And she remembered again what she already knew from working with First Nations children and women from the north, from her work in homecare. She remembered that until you know someone else's world well enough, you aren't likely to be able to be helpful to them.

Looking outward from this story to the stories occupational therapists tell about occupational therapy, I think about why this story was so powerful when Katherine shared it with me and then with the research group. I wonder what it touches and touches on. I think of Labovitz's (2002) book *Ordinary Miracles* about people overcoming illness and injury with help from an occupational therapist to re-compose a life. Inquiring, I re-read portions of Carlova and Ruggle's *The Healing Heart* (1961) about an early occupational therapist's stories of working with injured soldiers. I recall Hocking's (2007) analysis of occupational therapy stories or stories of occupational therapy, in which she identifies traces of the Romantic ideals which she identifies as one of two strong threads (along with rationalism) that continue to influence

occupational therapy practice. Hocking (2007) describes these stories as reflecting Romantic assumptions about transformation through simple doing (p. 27), about clients' "potential to transcend their circumstances and discover their spiritual essence" (p. 28), about clients' pride in their accomplishments (p. 28). While Hocking looked at arts and crafts occupations-as-means in exploring these Romantic roots, I wonder if even this seemingly simple act of making coffee had the power to transform this client's view of himself, to help him gain hope for his future. I think about this client reporting with pride that he had taken the garbage out. I wonder if the Romantic thread is woven around, and through, occupational therapy's "sacred story" (Crites, 1971) – that story that is almost inexpressible, that is more a dwelling in which we reside. Is this why, when Katherine tells this story of making coffee to other therapists, their eyes well up too?

You are touching a healing force

Looking outward again, and at a slightly different angle, I wonder about co-occupation in this story. Pierce's (2003, p. 199) definition of co-occupation is something that is highly interactive, relies on the synchronous to-and-fro between individuals' occupational experiences, and shapes the actions of the other. Pickens and Pizur-Barnekow (2009, p. 152) propose to extend that definition and suggest that co-occupation involves shared physicality (reciprocal motor behaviour), emotionality (mutual response to another's emotional state) and intentionality (mutual awareness of each others' role and purpose). They further describe co-occupations as

"embedded in shared meaning" (p. 152), and emerging through interactions. They discuss this mostly in terms of parents and children, or individuals and their caregiver. As I look at this story, however, I wonder how often co-occupation is co-created between therapist and client. During the clinic visit that Katherine describes in this story, there was shared physicality – in the testing area Katherine would have been setting up the lifting equipment and then having her client work with it. There was emotionality – the client's increasing, and non-verbalized, anger and, likely, anxiety, and Katherine's fear as she tuned into what her client wasn't telling her in words but somehow in his embodied actions. Katherine's comment to her client definitely went beyond the typical language of assessment and interview – evoking emotion (and careful not to evoke negative emotion), connecting the client to something he could touch, something he could hold on to. So is that another example of shared emotionality? As to intentionality, that seems to have been present, as both Katherine and the client were aware that the purpose of the assessment was to gain relevant information for the client's lawyer to use in pursuing a lawsuit against the person who had injured him.

Inquiring into this story, I consider Mattingly's (1998) argument that occupational therapists co-construct "healing dramas and clinical plots". She sees this *therapeutic emplotment* as central to the healing power of therapy. As Mattingly (1998. p. 6) says, "They [OTs] are in quest of dramatic plots that will transform the painfulness, irrelevance or sheer tedium of therapeutic activities into important events, ones that figure for the patient as critical

episodes in their healing experience." This story of making instant coffee becomes a story of how the client will be able to begin to heal. That the client returned a week later full of pride about having taken out the garbage, shows me that Katherine was successful in co-creating a story of healing that comes from engaging in the world, from touching the world. Katherine also commented that in asking her client to make coffee, she was asking him to momentarily move from his role as someone who received help, to someone who was able to be a host, to offer sustenance to someone else.

In looking outward yet again from this story I also wonder about Price and Miner's (2007) discussion of occupation-based practice. They propose that occupation emerges during therapy, as a consequence of the therapeutic relationship, therapeutic strategies employed by the therapist and the meanings that therapist and client create in working together. The meaning that Katherine and the client created in making coffee emerged in therapy. Katherine was attuned to the client, strategically used what she knew about the client not being able to say no to "nice ladies" to ask him to take on an everyday task, and described everyday doing, like making coffee, or taking out the garbage, as touching a healing force. This seems to have been helpful to the client.

I think too about place as I inquire into this story, and Katherine's comment about how the clinic space that she was able to design was conducive to being able to have lengthy, uninterrupted conversations with clients, being able to make a cup of coffee. This is not common in many places

where occupational therapists practice, and clearly something that Katherine was able to take full advantage of in this practice place.

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Painting a picture of the birdhouse-builder

Katherine spent most of the final phase of her career in private practice, doing medical-legal work. As mentioned previously, she was one of first occupational therapists in her province to do this as a private practice, living out again her familial story of being a pioneer. She had left her position at the rehabilitation facility after realizing she was not enjoying the work. Before she launched her private practice she took a few months off to explore her options. One of the things she looked at was:

> [K] … doing people's life stories. Going out and interviewing people like you're doing right now. Putting it into a book. And I went and talked to a guy about printing books – there weren't any instant publishers in those days. And a book almost literally fell off the library shelf about a very similar thing, about creating a video. But when I thought about it more I thought, 'This is really energy intensive. I don't think I could get a product that I would be happy with, without it taking a lot of hours. So I don't think people would want to spend that much on it. It would be like writing a novel, a short novel, but a novel.' And I thought, 'I can earn a lot more with my writing skills doing medical-legal work and people can pay, people are willing to pay for that.'

Katherine realized that she was really interested in listening to people's stories and in creating something that accurately represented what she had heard. She knew she had the writing skills to do this, but was not sure she would be able to make a living at it, unless she was willing to produce work that wouldn't meet her own standards. She saw that medical legal work

would give her a chance to use her skills and everything she had learned in her previous work as an occupational therapist to be able to make a living.

It's such a foundation for all the other life events that go on

When Katherine did open her private practice, she found that, as she had working in her first medical-legal position, she really enjoyed the opportunities this kind of practice gave her to spend time getting to know clients with whom she was working. She could and did have time to listen to their stories. She found that her previous experiences as a student and occupational therapist in mental health were very useful:

> [K] People are still people, and all of those emotions they have and the roles they have, and all the problems they've had in their lives before; they're always there. I've always felt the mental health stuff is the foundation, because it's such a foundation for all the other life events that go on.
>
> [K][DP1] It's important that I did my first year in psychiatry. That was really useful…

She had the knowledge to see people as people, not as individuals with a physical or mental illness or injury, and to understand that everything they brought to the moment at which she met them was important to her understanding of how to move forward in her work with them. She had been able to watch one of her mentors during that first mental health job find ways to draw out clients' life stories. Katherine, too, drew out these stories and found ways to recount these stories. She says she asked clients:

> [K] Do you want to show me some aspect of your life, and I can write it up in a way that someone else can understand? I can paint the picture because I understand well enough.

Understanding well enough doesn't come quickly. Katherine said:

> [K][DP1] I think that you need to give people time to let you into their world. You just have to shut up for awhile, or ask questions and just listen. It's really hard to see past what you think their world is, your own assumptions about their world. And you don't even know what assumptions you're making when you start out. There are all sorts of things you're assuming and sometimes they'll say something and you'll go, 'Ooh, I realize I had a wrong assumption.' So if you give them enough time, you're asking enough questions, if you are open enough, if they trust you enough, then you find out so much more that you really need to know before you can do anything.

Katherine knew that it was only through listening and letting go of her pre-conceived notions, of establishing trust, of being open that she could know enough to be able to do something useful. This knowing was essential in her medical-legal practice. When I hear Katherine talk about how she arrived at knowing enough, I think about Reid's (2009) idea of *presence moments* in occupational therapy. Reid says that therapists become mindfully present through taking stock (of their own feelings and thoughts, and of the client's situation), being actively available, asking themselves reflective questions, and practicing being curious and open-minded (pp. 184-85). Reid encourages therapists to work toward this ideal and notes that experienced therapists who have mastered the procedural aspects of therapy may be better able to do this. Katherine's description of the process of coming to *understanding well enough* suggests that this is something she does extremely well.

They were exquisite works of art

Katherine tells the story of one client she saw in her medical-legal practice:

> [K] And I remember there was one lady who was telling me about making birdhouses. So the picture I had in my head when she was describing this hobby was pretty bare-bones wooden birdhouses that you would whip together fairly quickly and you might paint or you might not, and stick outside, you'd hang it on a tree or a post. My God, when I saw them – they were exquisite works of art! They were amazing! They would have taken hours and hours; they were very artistic, beautiful, and hardly deserved the word 'birdhouse'. Some of them were Victorian. They were like little houses, exquisitely decorated, with beautiful taste and fine craftsmanship. And you know – that's not something you can drag into the lawyer's office just to say, 'I had this hobby and I want to mention on the stand what I've lost because I can't do it anymore now, it's too painful to sit. I've really lost something to not be able to do this.' 'So she can't make birdhouses, okay – not important!' So just to be there to really make sure you're getting the full story. Often people can't explain themselves and they don't know what you need to know. You have to know what you need to know. They can't jump ahead to understand what elements are important for them to share with you. And you need to keep going back and seeing those threads and making sure you've pulled them out and have gotten the full picture.

Katherine's client made birdhouses as a hobby. Katherine's assumption before taking the time to see these birdhouses was that they were likely simple, easy to build, birdhouses. Instead what she saw were beautiful birdhouses that would have required both great skill and considerable time to create. Katherine's experiences earlier in her career, of using art and crafts with clients, gave her the ability to appreciate just how much went into making these works of art. Katherine's experiences as a student with seeing the value, to the injured workers she met as a student, of *doing* that produced something tangible, such as a bread board or a bookcase, may have helped her see the value of building these birdhouses to this particular client. The birdhouses weren't something that could have been taken to a lawyer's office to emphasize that this client had lost the ability to do something very

important to her because her physical injuries made prolonged sitting painful. The importance of bird-house making to the client could easily have been lost in the courtroom. Katherine could see how her client's occupation could have been storied as something of no great importance. She could look out to the parallel universe of legal practice and use her experience in that universe to determine what she needed to know. Katherine's being there, listening to the whole story, meant she could start to look at the client in her context and pull the threads together that were necessary to be able to tell this client's story in court.

As I inquire into this story of bird-house building, I am struck by how much the core of Katherine's work with her medical-legal client parallels this narrative inquiry process in which she has been a participant. I think about how carefully Katherine attends to the relationships she has with clients. I notice how she holds seeing her clients' stories *big* while being able to move to seeing systems *small* when she needs to do so (Clandinin et al., 2006, pp. 162 – 163). She seeks to understand her client's personal "feelings, hopes, aesthetic reactions and moral dispositions" (Clandinin and Connelly, 2000, p. 50) as well as their "existential conditions" (p. 50). She carefully considers the impact of places. She looks backward to her clients' earlier experiences, to what their stories to live by might be, and be becoming. She spends the time to see clients in the present and is present with them, and imagines how to support these individuals in their possible futures.

Katherine worries about how often stories are left out in some medical-legal evaluations that she was asked to read:

> [K][DP1] What irritated me doing the medical-legal – some other evaluators – there was no narrative in there – there was no encouragement to hear people's stories.

> [K] I get so frustrated with these little standardized assessment batteries being run by people with minimal training because you get some results from the testing and you can use that. But you get so much more from what goes on along with the testing, with the attitude that people have about it, the approach to task, the way they talk to themselves about it. All those other things tell you way more and it's way more useful, equally as useful at least.

Coming from her experiences as a student, then as she practiced in mental health, vocational assessment, medical-legal and hospital management contexts, she has become convinced that assessments that do not include a narrative account of the individual being assessed, and an account of how that person went about doing tasks, are missing crucial information. She had learned early, from her experiences working with First Nations children and women from the North, that she needed to see people within their own places to be able to understand well enough. So seeing these birdhouses when she visited her client at home opened up new possibilities for knowing, and thus new possibilities for recounting, this woman's stories.

I kind of see it as a spiritual practice

Katherine acknowledges that the context in which her medical-legal work took place is very often not a pleasant one:

> [K] And you know it's a nasty process they're in. It's a very unpleasant, invasive kind of experience for anyone who's been in litigation. It's really horrible. I mean not only do they have something bad that's

> happened and something that hasn't gotten better, or not better enough, but also once they enter the litigation process they're exposed. This is what's so different from being in the hospital. Nobody is saying, 'We think you're cheating, we think you're making things up or making them worse.' And that's sort of where things start in litigation. There's the other side always asking you questions or sending you forms or sending you off to be examined by other people. And I'm one of them. No matter what side I'm on. The OT going out for medical-legal is going out there to see if you're legit and get the facts and maybe might think you're not legit. So it's pretty unpleasant for people. So my goal was always to go in – I kind of see it as a spiritual practice – one of the things I see as my 'ministry' is to go in with an open mind and open to learning who the person is and learning their life story, which doesn't mean I believe everything they tell me. But it means I'm really wanting to understand what they're telling me and willing to go down some of those roads quite a long way to try and understand what they're telling me. And why they might be telling…

In medical–legal practice the client is opened up to ongoing appraisal by a number of people. Clients are sometimes assumed to be making things up, unlike hospital settings where generally people are assumed to be telling the truth and making an effort to recover. As a medical-legal occupational therapist, Katherine was one of the people who would be examining a client, as their lawyer(s) were building a case for court. In this context, Katherine sees her work as having been spiritual, her mission being to enter into a situation with an open mind, to try to understand what an individual was telling her, and to think about why she might be being told certain things. Katherine says of her spirituality in (her) practice:

> [K] We don't openly acknowledge spirituality. At least OT in Canada does put it in the center and does talk about a little bit. But I think lots of people are still uncomfortable with that. I think it really makes a difference to kind of therapist you are, to be able to do that.

In Canada, the conceptual practice model that many occupational therapists follow is the Canadian Model of Occupational Performance and Engagement

(CMOP-E)(Townsend and Polatajko, 2007). This model views persons as having a spiritual core – spirituality being seen as whatever gives meaning and purpose to an individual's life. People are seen as having physical, cognitive and affective abilities, which, energized by spirit, are used to engage in occupations within environments having physical, social, cultural and institutional attributes that support or constrain doing. Katherine believes that this focus on seeing what brings meaning and purpose to life has influenced the way she practices as an occupational therapist. Katherine notes that talking about spirituality is not something that many occupational therapists seem comfortable doing, whether in discussing their own practice or clients' spirituality. This observation is supported in the literature. Belcham (2004) found that her OT respondents believed that spirituality was important, but did not consistently address it in their practice. Smith (2008) describes the struggles the occupational therapy profession has encountered in defining spirituality and proposes a flexible framework for representing spirituality rather than a specific definition. Wilson (2010, p. 437) explores whether spirituality is a "legitimate sphere" for practice. Kirsh (1996) describes the value of a narrative approach in occupational therapy, and the value that attending to narratives may have when working with spirituality in mind.

Katherine *is* able to talk about spirituality within her practice, but she was concerned when she read the transcript of our discussion that the distinction was made between spirituality and religion. She was wondering if

'ministry' was the word she really wanted in talking about the core of her practice. I look backward from this story of learning about the birdhouse builder to her story about making coffee. Yet again, part of the conversation she had with that client was one of a spiritual nature. She talked about touching, doing, as a way of connecting with healing forces in the world.

In one of the research group meetings, Katherine talked about a new pursuit she has taken up, photography:

> [K][DP1] It's almost a spiritual practice. An act of learning to see and appreciate the now. And then I look at my photographs over time again and it brings back those memories. I think, 'There's more in there that I didn't see the first time around.' Now I can actually take the time to look at that, or to enlarge it and look at it, and there's things I missed that I'm enjoying seeing.

Her description of photography as another form of spiritual practice, one that requires that one stop to see, and to be in the moment, resonates with how she has described learning more about the bird-house maker. Her stories suggest that, just as with the photos, she is able to be in the moment, to see stories 'big', and to re-examine what she's heard/seen and see it with fresh eyes. It brings forward her mother's words about being kind and understanding people – how Katherine has done this is by taking time to be with, and understand, her clients, to see people in the places in which they live and, through this, to know enough to help her clients.

In retirement, Katherine continues to volunteer, helping adults learn to read. As she told stories of the individuals she had tutored, she said:

> [K] It's very much doing OT, I just mustn't call it that.

She talked about how she used all of the skills and knowledge she has developed over a long career, how hard it is to leave a profession that she has practiced for over three decades. When I hear her talk about tutoring, I think – she finds ways to know enough.

Pausing before going on

This narrative account of Katherine's stories of doing occupation spans a career in which she has practiced in hospital, agency, clinic and her own private practice landscapes. In this account I have re-told four stories through inquiring within a three-dimensional narrative inquiry space – looking forward and backward, inward and outward and at place. In this inquiry process, I have come to consider more deeply the importance of 'world' travelling and loving perception (Lugones, 1987), empathy (Peloquin, 1995), co-occupation (Pierce, 2003; Pickens and Pizur-Barnekow (2009) as a co-creation between client and therapist, the Romantic ideals of practice (Hocking, 2007), the possible link between the narrative inquiry process and this therapist's practice, the importance of presence (Reid, 2009), and the impact of spirituality in practice.

The following narrative account is of Dawn' experiences of *doing occupation* as she worked in two different countries and healthcare systems, and moved between acute care and rehabilitation services within one system.

Chapter Four: Dawn

Introduction

In this chapter I introduce Dawn, re-tell and inquire into stories of her experience of *doing occupation* during her career as an occupational therapist. Using the three-dimensional narrative inquiry framework as a guide, I travel backward and forward exploring continuity, inward and outward to examine sociality, and see a variety of practice landscapes, places, within Dawn's stories. I look for continuities and discontinuities in how Dawn is *doing occupation* and how her stories to live by and her personal practical knowledge bump up against other competing or conflicting stories in the healthcare landscape.

Introducing Dawn

Dawn is a European-educated occupational therapist who was identified as being particularly occupation-focused by a professor with whom she had taught a course, based on conversations they'd had in class and while designing the course. She comes from and was educated in, a western European country that, during the time she was growing up and attending school could be defined as strongly influenced by social-liberal ideas.

When I asked Dawn if she would be willing to participate in the study she, like all but one of the study participants, asked me if I was sure she was

the “right person” to ask. What made me hope Dawn would say “yes” to my request, beyond the recommendation from my colleague, was that she has practiced in two countries with very different healthcare systems, and in both acute care and longer-term rehabilitation settings. She was also the only participant other than myself who had worked as an OT outside Canada. I knew that would provide an opportunity to hear about her experiences in alternative professional practice landscapes. I was also interested in her stories of experience as someone who has been practicing for about 15 years, as the research team included three people (including me) who had worked as OT’s for twice that time.

Dawn told me about her OT career and shared some practice stories both in an individual meeting we had in my university office space, and during three research group dinners. She changed workplaces between the interview and the first research group meeting. Dawn was unable to attend the final meeting of the research group. Four practice stories are explored in this chapter: an ADL story, a cooking story, a story about tabletop activities and a story about jewellery making.

⊙

Basic ADLs: *she could do more and she wouldn't*

Occupational therapists often work with clients who themselves are concerned about returning to, or maintaining their abilities to be clean, clothed and well-nourished, either through their own efforts or with varying degrees of assistance from others. On some occasions, the occupational

therapist might initially be responding not to clients' concerns, but to questions from other healthcare staff or family about client abilities to perform these basic activities of daily living (ADLs). Dawn tells this story about ADLs with a client she had in her first workplace in western Europe. In this extended care place:

> [D] We had this lady from Pakistan and the nurses wanted me to do an ADL assessment on her because they were having a hard time. They felt she could do more and she wouldn't do it. And they didn't know what the problem was and they couldn't get to the bottom of it. So could I do an ADL assessment and figure out what this lady could do? So I go in and it's just the hardest ADL assessment – I asked her to wash her face and she's not doing it, I asked her again and then with a lot of encouragement she's finally washing her face. And then, step-by-step, every single task was kind of like that. It was me really pushing her and so I couldn't figure it out. So I did come back to do another assessment, but couldn't figure it out. I did maybe a handful of assessments and I wasn't sure what the problem was, because she could do it and she couldn't do it, right? And so I just owned up, I said, 'I'm here to determine what you can do and what you cannot do and I'm going to have to tell the nurses and whatever I tell the nurses, that is what the nurses are going to do. So if I tell them that you can wash yourself and you can dress yourself the nurses are going to want you to do that every single morning but if I tell them they need to help with that, they'll give you help with that every single morning.' So I really tried to explain my role and that my recommendation was going to be followed – which is true. And, so then it came out that in her culture it was, if you were sick, your family needs to take care of you and she was really angry with her kids because here she is with, I think she had Parkinson's, getting dependent and her kids are lacking in their responsibility. They're not taking care of her and that was totally her expectation. She's sick; people need to take care of me. So then I asked her 'What do I, want do you me to tell the nurses?' And that's what she told me. She wanted help, so even though she could do it, that wasn't her priority, right? She wanted help with that. So that kind of went against what we learned in school that independence is important and that as OTs you're trying to get your clients to be as independent as possible, and it kind of runs against the grain of my [laughs] schooling in a way.

Dawn tells this story of a clinical puzzle she was faced with. The nurses suspected that this client who *wasn't* doing her ADLs by herself, *could* do them. As the identified ADL expert on the team, Dawn was called upon to answer the nurses' question about the client's ADL abilities. Her initial response was to have the client show her what she could and couldn't do, assessing her on several occasions. The answers she got from assessing the client didn't add up. Something was missing in her understanding of this client's stories to live by. As she talked with the client, she found out that this wasn't a story of can/can't, but a story of unmet expectations about family members caring for ill elders. She came to understand how angry the client was and that the client wanted help from the nurses (in lieu of the help she had hoped for from her children). Knowing this, and likely thinking forward to how the client could come to be labeled as difficult by the nursing staff, Dawn contested some of what she had learned in her professional knowledge landscape about the importance of independence, and recommended that the client receive assistance. As we inquire this story, what are some of the experiences that made it possible for Dawn to do this?

I remember I had a black doll

Inquiring into this story of ADLs in this extended care place in which Dawn practiced, I consider how this story could be wrapped alongside another story she told me looking backward and inward to her childhood:

> [D] And I think also in my upbringing – as well my mom. I remember, I had a black doll, a little black dolly. Who had that: that's in the 70's? There were hardly any black dollies around, right? And I had one. So

> there was always that emphasis around our home that people were equal …

Dawn comments that she learned from her family that *all* people had the right to have their practices and preferences respected. She says that this focus on equity and diversity is part, too, of the culture of her country. Talking about her practice as an OT now, she says:

> [D][DP1] It's people from different walks of life as well, and who go against the grain of what you think is important in life and you kind of help them on their path. Or other cultures.

As Dawn worked with this client in her first work place, did she eventually pull forward her childhood stories to live by of being attentive both to difference and to equity – that people weren't the same, but had equal rights? She was working with a client who came from a different cultural background than hers, and initially seems not to have considered that the client might have different stories to live by about independence in ill health, shaped by cultural narratives, than she did. Meeting multiple times with the client to try to understand the discrepancies both she and nursing staff had noticed about the gap between what the client *could* and *would* do, Dawn first relied on her professional training in assessing ADL abilities. It was when she called on another professional skill, *narrative reasoning*, one perhaps intertwined with her childhood stories to live by, that she began to understand her client. Through talking with the client, she came to an understanding of her client's past, thought about how this past shaped what was happening in the present, and about possible futures. She considered

how age and ill health, how living in another culture, had interrupted not only her client's narrative, but also changed the stories her client's family were living out. Occupational therapists would name this narrative reasoning.

The strength of OT is to connect that story

Looking backward and outward to Dawn's professional education, the value of a variety of types of clinical reasoning – procedural, interactive, conditional and narrative (Mattingly and Fleming, 1994) was being widely discussed in the professional literature. Narrative reasoning – thinking about clients' pasts, presents and possible futures – is something Dawn mentioned several times in our research discussions as an important strength of occupational therapists:

> [D][DP1] I think that whole narrative reasoning is part of OT, a big part.
> [D][DP1] The strength of OT is to connect that story. Not only to get the background and what's current but also look at how it's going to impact the future for that particular person, because it's going to impact people in a different way. And I think that's part of the OT role, that's what we bring to the team, to say 'You know what? This person is going to do this in the future and this is going to happen' and kind of play into that. More so than other professionals, because I don't often see that others see it the same way.
> [D][DP1] What's important to this client, and what world is he living in, but also the future, how's this going to impact this future person?

Dawn mentioned that across the times and places she's worked, she has noticed that occupational therapists seem to have a perspective that she believes means they know more about the client than other team members and can anticipate future issues:

> [D][DP1] Kind of interesting, how often that happens – that you're the only team member knowing stuff.

She thinks this knowing comes from narrative reasoning.

Narrative reasoning requires both the ability to connect with clients and to understand how they story themselves and their worlds. Looking backward from the temporal location of this ADL story, I wonder if Dawn's admiration for one of her professor's skills in connecting and relating is reflected in what she tried, and tries, to do in her practice:

> [D] She also had the ability of relating well to the students but she was still the professor, so you were respectful of her. She was really approachable and you could really easily connect with her. She was one of those people who just have that ability.

Did Dawn's ability to have a frank discussion with the client, to connect and to relate, give her a window into her client's life that let her use narrative reasoning rather than narrower ways of understanding this situation? I wonder if this an example of Dawn learning how to be a "*world* traveller" (Lugones, 1987) who could see beyond her own cultural narratives about independence and dependence, about family members' roles, to those of her client. With this new perspective, she was able to better understand the inconsistent clinical picture that was painted by nursing staff and was initially part of her assessment findings. Gaining this understanding, she began see that she needed to advocate for her client to be offered help with her ADLs every day. Advocacy is not something Dawn shies away from, and is one of her stories to live by from early childhood.

So that he wasn't standing alone by himself

One of Dawn's stories to live by about advocacy comes from her early school experiences:

> [D] So one of them was that in elementary. We had small classrooms, there were only 12 of us. We had one little guy and nature had been fairly unkind to him, first of all. But then his parents were making him a bit of a go-ahead for all of the kids to tease because he was kind of tall and slim, so his mom would actually sew different parts to his jeans to make his jeans long enough so he could wear them. But of course, he would look horrible, right? He became the little kid to tease and I was actually the kid who prevented that from happening – not prevented it from happening, but I would actively interact with him in the groups so that he wasn't standing alone by himself.

Here, like with her client from Pakistan, Dawn had to think through difference, and to what she could do in order to not have someone treated unfairly. Dawn could see how her classmate had become an object for teasing because of his physical appearance and dress, and looked ahead to how that would change how he saw himself. She looked ahead to what she could do to prevent the teasing from continuing to happen. Then, in that long ago classroom and schoolyard place, Dawn stepped forward to advocate for someone who was different. Later, as a young therapist in the extended care place where her client came from a different "world" with different narratives about independence and being cared for, it seems that Dawn again lived this story of standing alongside, this time advocating for her client when the client's stories to live by were not congruent with those of the staff. That she had to advocate for the client in terms of difference is interesting, given the landscape within which this story happened.

All of the activities were geared towards that specific population

This experience took place in a facility that was attempting to live a story of being sensitive to clients' backgrounds. Different units had different themes, and clients/family could choose the unit on which they wished to live. For instance:

> [D] One of the units was the ethnical background theme. Most of the residents were of Indonesian or Sudanese background or some Muslim, background because that tends to be the immigration into [her country]. The dress-up of the unit itself – the living room had more of… patients could bring in their own furniture. Not all of it of course, but they could bring in one piece of furniture and then also some paintings. So the dress-up of the unit was completely different. But also the activities by the rec therapists were different. So they would cook rice and have rice meals or their music would be more a mixture of ethnical music. They would make rotis instead of bread or all of the activities were geared towards that specific population. Then we had, like business backgrounds, so they would have …
> [S] This is fascinating, I had no idea.
> [D] This is what a nursing home should be like! So the business units – so the dress- up was different. They would have napkins at their meals and wineglasses and their music was different and they had, you know, more like CBC radio on instead of music. Activities from rec therapy were to read the newspaper to the residents every single day and talk about the stocks and those kinds of activities.
> And we had what we called the homemaker units, so mostly moms and people who've never worked outside the home. Then some of their activities were more around cooking and baking and they would bake pies and wash their own beans.

As Dawn described these spaces within the extended care place, it was clear that she could see the benefits of creating units that provided some degree of continuity between clients' lives in the community and in this new landscape. Dawn's story of ADLs brings forward questions about the extent to which planners and especially staff understood deeply held beliefs that some of the older residents from non-European backgrounds had about being taken care

of by family or, in lieu of family, by staff. Beyond furnishings and food and activities, we all carry many stories of how daily life *should* be lived. For Dawn, this experience created tensions between her own values and beliefs about equity, her belief in client-centredness and advocacy, and an enduring story that OTs live out in the practice landscape about the value of independence. Perhaps her ability to be a "world" traveller gave her new possibilities as she navigated these tensions.

Kind of runs against the grain of my schooling

As I continue to inquire into Dawn's story along the social dimension, I am also wakeful to the professional socialization Dawn would have experienced as a student and when she entered practice. What would she have learned about independence? Until recently, occupational therapy has somewhat uncritically espoused the western cultural value of independence in daily life as a key outcome of therapy, even though, as Tamaru, McColl and Yamasaki (2007) and Bonikoski, Musto, Suteu, MacKenzie and Dennis (2012) point out, the construct of *independence* is both poorly defined and shifting. While this focus on independence has been contested eloquently by occupational therapists Whiteford and Wilcock (2000), Iwama (2006) and Hammell (2009) as representing only one possible worldview, independence rather than inter-dependence is still often what occupational therapists work toward with clients.

So that might have been both what Dawn expected of herself, and what she anticipated the other staff hoped she could help this client achieve. Did

this create a moment when Dawn was caught between competing stories of what she should do? Another commitment from her education, of being client-centred, may have helped her to negotiate these competing stories so she could recommend that nursing staff routinely assist the client with her activities of daily living. This would be very much congruent with Dawn's personal practical knowledge as an occupational therapist with regards to being client-centred – working towards goals identified as important by the client, and honouring clients' needs and preferences where possible.

Cooking: I wish we had a real practice kitchen

One of the things that occupational therapists often do is to see if clients are able to safely function in the kitchen when preparing food. Dawn described how in her current practice in a rehabilitation hospital, the cooking assessment is part of an evaluation called the PASS – Performance Assessment of Self-Care Skills (Rogers and Holm, 1994):

> [D][RDP1] The test is a standardized kitchen assessment so you get your patients to make muffins, soup, peel an apple, and all of it needs to be finished at the same time. So they're standardized, in that the muffins must be made with water, the soup with milk, and everything is set up. There's pictures of the set up, so the kitchen is set up according to the standards. So it's the same thing for every patient, and you just kind of slot your patient in there and get them to do these tasks. They are novel sometimes to the patients. The kitchen can be completely novel, some of the tools can be novel, but some of the activities as well.
> [K] It's one person's parallel universe that they're working in.
> [D] I had one patient who said, 'I don't really like apples, so why am I peeling an apple?' And I'm, 'yes, I'm not sure why either, but just go for it!'

As I looked temporally backward from this story of practice in Dawn's current place to her stories from another place in an acute neurology unit of a large Canadian hospital and then even further backward to the first place in western Europe where she worked as an occupational therapist, I saw connections across the stories Dawn told about trying to use cooking with her clients.

Dawn talked about the challenges she experienced in the acute care place she was working in when we had our first conversation. When trying to see if clients could safely complete simple cooking tasks she said:

> [D] Like we used to have a little toaster in our kitchen and I could get my patient there to see if they could toast some bread. But the toaster has been gone for years.
> [S] Oh no!
> [D] Yeah, and every time they replace it, it's gone again, 'cause people steal it.

I asked Dawn whether there was a kitchen in the occupational therapy area within the acute care place:

> [D] There is. There is one in central rehab and the one in central rehab has, again, a lot of things stolen so if you want to, as I've tried. So first of all, you have to navigate where the key is and nobody knows, and then the key disappears. And you have to make sure that no one else is using the kitchen because it's an active treatment area that's occupied quite a bit. And then oh, for lunch you can't use it because all the therapists are eating their lunch in it. And then you have to, really, bring in stuff from home because most of the equipment is gone out of the kitchen. You can hardly find a pot. Then there is no funding for the produce, so you have to get family to bring in produce for the patient. So you have to coordinate that …
> [S] I can see why it just becomes really hard.
> [D] Yes. And then with your patients you've got it all organized. You've got the family bringing in food, 'cause I've done this a few times. I've located all the utensils I needed and I've got them hidden away. I've brought some stuff from home that wasn't there and got my patient organized in order to do it, and I'm about ready to bring the patient

> down. Then they're either incontinent and they need to be changed or they need to go for a test or … [laughs].

Dawn said that she had been pleased when a new unit with a kitchen area opened in that acute care setting – although some of the same issues remained:

> [D] Cardiac has a kitchen as well that is actually quite nice and has more equipment in there as well. But again the issue remains that you don't have access to produce, so you have to get family organized and bringing that in and getting your patient, organizing them.

What is clear in Dawn's practice stories from an acute care landscape was the great lengths Dawn went to in order to be able to use cooking with her clients: bringing in cooking tools, claiming space, collaborating with clients' families, persevering in her efforts to see if her clients who needed to be able to safely cook when discharged, could do so.

Looking backwards again from this practice landscape to the one where she worked as an occupational therapist in western Europe years earlier, Dawn tells a different cooking story:

> [D]… a real practice kitchen. And that's what I had in [in Europe]. We had a high/low kitchen where you could get the countertop at the right height and all of that.
>
> In [her country] we had little budgets, so specifically, including our kitchen. We had an assistant. You could give her a list, 'this is what I need' and off she'd go to the grocery store with a little cash and come back and you had all the groceries you needed. So it was kind of, not this whole big production.

While working on cooking activities in the extended care facility in her country, sometimes she would go out with the client to buy groceries:

> [D][RDP1] The facility was in the center of [large European city]. So I could often go with the patient and have the patient do the grocery

> buying. The LRT would be in the middle of the street, and then there were cars, then there was the bike path and then there was the pedestrian path, so even crossing the street was kind of an observation…

In placing these three stories side-by-side, I've started my inquiry by looking temporally at Dawn's experiences of using the occupation of cooking with clients. In looking backwards, what is initially most apparent is the importance of *place*. In the practice landscape of her European extended care facility she could easily access not only the physical place ["a real practice kitchen"], along with the tools and foodstuffs she needed, but she could also travel out into the community with her clients to buy groceries in places that were familiar to her clients. The practice of cooking was linked to the lives of the patients. In the acute care setting where she first worked in Canada, none of the places that might have been used for cooking by Dawn with her clients were really accessible or familiar to them. On the acute care unit there was a little kitchen:

> [D] The kitchen at the hospital doesn't even resemble a kitchen, it's a really a mechanical kind of, you know it doesn't, the taps don't even make any sense. You can't even see the taps. It's, anyhow it doesn't resemble a kitchen…

In the rehabilitation place in which she now works, it isn't so much that the kitchen isn't "real" but that the tasks are a contrived part of a standardized assessment. In addition, if she wants to just have a client prepare a meal, she needs to arrange that a week in advance. As she says:

> [D][DP1] Often I don't know a week before that I'm going to do a kitchen assessment. I often just buy it myself because it's usually just the vegetables I need.

Across these two places in Canada, even though she faces challenges, Dawn continues to find ways to use cooking with her clients. As she does so, she faces tensions in her practice related to equity and justice as discussed in the next section.

Feels false, unfair

Inquiring into these cooking stories from different times and places along the *personal/social* dimension, I think about Dawn's comments about learning as a child about the importance of being fair and equitable:

> [D] I'm not sure if that's part of [her country] society because it is, every single person in [her country] needs to be able to access the same things and has the same rights…
> So there was always that emphasis around our home that people were equal.

Dawn now finds herself using a cooking assessment, the results of which she realizes will affect whether or not a client will be able to return home or can access further rehabilitation. For Dawn, this use of cooking as an assessment brings forward questions of fairness and equity. In talking about the standardized assessment she is mandated to use in her current workplace she says:

> [D][RDP1] Goes against the grain of me to have these patients do these tasks. Feels false, unfair – for instance, *I* never really make muffins.

In this assessment, she's asking her clients to do something they may never have done before, and then assessing their abilities based on that; she sees this practice as being unjust. She thinks about how she would do if she was the one being assessed on her muffin-making ability, not being someone who

herself makes muffins. She further says about fairness in assessment and her concerns about what she does now:

> [D][DP1] That's not really my philosophy – I'm trained in the AMPS [Assessment of Motor and Process Skills]. I'm way more for, 'why don't we just get the patient familiar with the environment and see how they cope within their own activities and even with their own systems and habituations and see how they cope?'

Rather than assessing clients in contrived situations as she is being asked to in her current practice landscape, Dawn sees how much fairer these assessments could be if clients were doing familiar cooking tasks that they chose, in familiar places, and in ways that are typical to them. She sees that the assumptions on which the cooking tasks are based might be faulty:

> [D][DP1] Most of the patients, especially in the stroke population, there's people with co-morbidities, with certain histories, alcoholism being one of them, so not everyone walking in the doors has maintained a certain lifestyle.

The ecological validity of her assessment practice is of sufficient importance to Dawn that she has chosen to become certified in administering the AMPS, a commitment that has involved both considerable time and expense on her part. The AMPS has clients choose familiar activities and tries to assess ability in an environment as close as possible to that in which they would normally be living (Center for Innovative OT Solutions, 2013.). Being asked to use an assessment that may disadvantage her clients and have major repercussions in their lives creates a contradiction for Dawn. She finds herself living a practice that creates contradictions with her stories to live by threaded around equity.

Went way beyond her duty

As I inquire into Dawn's cooking stories that she has struggled to continue over many years and in different places, it is evident that she is concerned about equity and also very dedicated – going that extra mile – to make these cooking experiences possible for her clients. I hear her comments as she looked backward and inward to one of her admired early clinical preceptors:

> [D] One of my preceptors actually… she seemed to have a real care for her patients and she had a really holistic view as well. And she just explored all the different areas of occupational therapy and she went way beyond her duty really. Like really tried to accommodate the client as best. And tried to collaborate with them on what was important for them in their lives and what they wanted to do and then really put in her best effort to try and accomplish that.

She met this preceptor when doing her fieldwork placement in Canada many years ago. As Dawn says:

> [D] And I'm, that's the thing, I'm not easily impressed with people. That's why I was asking, 'can I make it broader?' Because it takes a lot for me to really respect people that way.

Dawn very much admires this therapist for her willingness to go beyond what might have been standard practice, collaborating with the client on what they thought was important, and putting her full effort into trying to help the client do what they needed/wanted to do. Inquiring into Dawn's cooking stories, I see her doing much the same thing. She persists in doing cooking activities, even with the challenges she encounters, if that is something that is important to her clients. She collaborates with clients and

their families to try her best to be able to do this, through persevering in finding and booking appropriate spaces when she can, through bringing in tools from home, and asking families to bring in produce when it's not available in the hospital, or even shopping for produce herself.

We are supposed to be client-centered and holistic and advocate for our patients

In continuing to inquire into the *social* dimension of these cooking stories, I wonder if Dawn's dis-ease with these "unreal" kitchens and contrived tasks may also come in part from her professional education in western Europe.

> [D] And our background – we mostly had Kielhofner, and Reed and Sanderson. And the OPM [Occupational Performance Model] was just up-and-coming at that time.

Looking backward, she entered the profession during a time when there was an increased emphasis on occupational therapists being client-centred, and on using occupation in assessment and intervention. Much of the discussion of client-centred occupational therapy practice at that time came from Canadian occupational therapy leaders whose ideas about client-centredness were expressed in a model for practice (OPM and later COPM) that Dawn refers to in describing the curriculum content at her university in western Europe. A professor she admired had studied with Gary Kielhofner, a particularly influential occupational therapy researcher and educator who encouraged occupational therapists to be more occupation-focused and was instrumental in supporting the development of occupation-based

assessments like the AMPS. Her class studied the work of this scholar quite extensively and his work still guides her practice.

Dawn commented frequently on her commitment to being client-centred:

> [D] I think that's part of OT, right? That we are supposed to be client-centered and holistic and advocate for our patients. We actually take an oath in [her country] to do that as well, and it's different from a medical oath. It's a therapist's oath.

Dawn's cooking with clients as part of her practice in her country shows this client-centredness. She learned this way of working with clients in her professional education but it was also was congruent with other experiences. Inquiring into her stories of occupational therapy education, I wonder about how this early emphasis on the importance of being client-centred and occupation-based, as well as her early experiences at home and school where she learned about social justice and equity, inform Dawn's practice now? When Dawn uses a cooking activity in assessment with a client who isn't particularly interested in, or worried about, cooking, does this conflict with her professional stories to live by of being client-centred? Does her preference for a "top down" or occupation-based assessment like the AMPS, speak to her commitment to being occupation-based? Does persevering to find a way to do cooking activities speak to her willingness to advocate for her clients and to respect and treat them fairly and equitably?

It's way more structured

When Dawn talks about her experiences in the healthcare landscapes in her country and Canada, she tells stories of differences. As a student completing a fieldwork experience in Canada, she remembers:

> [D] I thought there was more, it was more intimidating being at the [Canadian hospital]. There seemed to be more of a structure to the things you needed to do, more standardized assessments and anticipation of, expectation of OT as a profession. I found that there was more flexibility within the profession in [her country] in your goal setting and determination of what to do with the client.

Moving forward in time from her student experience in Canada to the acute care landscape in Canada where she first worked, she said:

> [D] It's way more structured. You see a patient at a specific time; it's kind of scheduled, your activities are more scheduled. You don't have the same amount of flexibility in what you do. The teams are completely different as well. Here there's still a strong feeling about, everybody's working out of their own little toehold. And the physician is largely in control of what you as a therapist need to do.

Both as a student and as a therapist, Dawn's experiences of working in Canada, in comparison to western Europe, are that here there is more structure, more expectation of what the occupational therapist should do (including the use of standardized assessments), more physician direction of the team and more protection of professional territories by team members.

Continuing to inquire into Dawn's stories about using cooking in assessing clients, I wonder if she might have been both trying to (1) take a "*top down*" approach that she sees as being client-centred and occupation-

based and (2) be wakeful to the need for her assessments and her overall practice to be defensible within the Canadian healthcare places in which she's worked. The AMPS is standardized, considered to have acceptable reliability and validity, and has been developed to take cultural differences in daily living activities into consideration. Being able to defend her assessment practices could be related to messages that Dawn has received, and is currently receiving, from the "*conduit*". The conduit is Clandinin and Connelly's [1995] metaphor for how theoretical information about practice *should be* is poured into classrooms and how this information influences or conflicts with teachers' personal practical knowledge. It is easy to see that in healthcare, the conduit will funnel not only messages from OT professional educators, leaders, regulators and professional organizations, but also imperatives from healthcare funders, individual hospital/clinic administrators, physicians and unit managers to occupational therapists. Because she has been a student and practitioner both in western Europe and in Canada, she has been exposed to a variety of messages about healthcare systems, and about occupational therapy, that undoubtedly influence her practice. As Dawn has moved between practice settings in Canada she has encountered different messages coming through the metaphoric conduit, even though she is still working with the same provincial healthcare system. What messages from the conduit does she attend to, and what can she/does she choose to disregard? And is it here that her stories to live by call her to

question the messages from the conduit that end up making her live out practices that are incoherent with her stories to live by?

One particularly loud message that Dawn experiences coming from the conduit is the call for evidence-based practice in healthcare. One aspect of evidence-based practice is using assessment tools that are seen to be valid and reliable. But this message from the conduit may conflict with Dawn's own sense that even these sanctioned tools do not capture what is important, do not take into account clients' backgrounds, current lifestyles and preferences, and, therefore, do not fit with her commitment to fairness, to being client-centred and holistic.

> [D] No, I think when you kind of look at OT as a practice and the more holistic view, I think I was doing that more in my setting in [her country] than I'm doing. The focus is completely different and I'm not sure if it's more the general practice versus being more of a specialized clinician, if that has something to do with it.

People seem to be more on their own little islands

Looking backward, Dawn talked about being part of a very active occupational therapy professional community when she was in western Europe:

> [D] There seems to be more emphasis on being part of the forward movement of your profession. So the expectation from the association in your continuing practice is that you're part of some groups. When I was working in the nursing home setting we had monthly meetings with other people from similar settings and we would talk about practice issues as well as collaborating with each other on, for instance, developing a whole electrical wheelchair evaluation protocol. So that everybody could use them, because every single person was having a hard time kind of determining what criteria to use with your clients. So we made it our own, developed it, and then it became a tool that all the different facilities were capable of using.
> [S] Great.

> [D] So that, but also even within the setting we were part of research projects that were happening, like we were active participants in that. And more collaboration with the University as well. I was in a committee for working with the University on some of the things we felt students were missing in their education and then collaborating with the University on how to limit that gap. And that was set up by the University. So they had OTs from different settings, from different areas of [the country] come in. And I think it was every 3 months we would meet. So there was more ownership in your profession, there's more collaboration between the different levels of OT. And there's more emphasis on how to move the profession forwards and I somehow seemed to be more in the know about what the profession was doing than I'm doing here, if that makes sense.
> [S] That is interesting. I wonder is it, I mean, do we somehow have people in certain roles that end up doing some of that stuff and it doesn't …
> [D] People seem to be more on their own little islands. Whereas in [her country] the islands were closer together and there were multiple bridges connecting the islands and trying to work towards a common goal…

As I inquire into this story of Dawn in her professional practice landscape in western Europe, I wonder how those experiences shape what she does now in Canada. I am particularly drawn to her description of islands and bridges. In Dawn's practice stories, I see her trying to be a bridge for her clients as she connects them to the places in their worlds that lie outside the hospital or clinic, to their pre-injury/illness lives, to possible futures that she helps them construct. She works with her clinical colleagues to collaboratively assist clients to meet goals; bridging between what her clinical colleagues do and how they see the world, and what she does and what she knows. I see her acting as a bridge for her students and new therapists as she helps them travel back and forth between classroom and clinical landscapes. She brings all of those islands closer together through the work she does everyday as an expert occupational therapist. And, as with her stories about "going beyond

her duty", she extends herself to do more through her association with the university as a clinical preceptor and guest lecturer and in the graduate studies she is now undertaking.

Dawn has had the experience of being part of an active professional community, and had an ongoing professional relationship with a university occupational therapy programme. Part of her personal practical knowledge is the value of working on professional issues as part of a community, and of contributing to the education of future occupational therapists. While she says this was a professional association expectation, it seems unlikely that all OTs in her country got involved in these groups to the extent that Dawn did. I wonder if commitment to her profession is part of her stories to live by she learned from her mother:

> [D] She's a nurse and then went into educating nurses, at the college level and then went into more of the Director level. So she became the Director of all the students in the acute care setting, so she had like 800 students or something. Plus, then, the practitioners as well.

In addition to this early experience of watching her mother help student nurses move into the clinical landscape, what messages did she get about her responsibilities to moving the profession forward during her education as an occupational therapist? How did the therapists' oath she took shape her valuing of these additional professional commitments? Looking forward from this story to what she does in her professional knowledge landscape now in Canada, I see continuities – she has been very willing to act as a preceptor, even during times of significant change and disruption in the healthcare system in which she works. She has also been much more involved than

many of her colleagues in sharing her clinical expertise in the classroom, working closely with several professors over years.

Of her acute care place, she said:

> [D] Here, it's more you go to work and you do your thing and you're kind of out there on your own. Like we don't even have a work plan at work. There are so many things we could be working on to improve even our little practice on the unit, but it's not happening…

Dawn's experience in this place is that her colleagues are not involved in moving the profession, or even the unit, forward. Her stories to live by that she lived in western Europe about being an occupational therapy professional are bumping up against other stories on the landscape in this acute care place in Canada.

I wonder about whether, in spite of her extra efforts, she sometimes feels alone on an island in this Canadian practice landscape. Looking backward and forward along the social dimension, I think about Craig's [1998] discussion of the conduit and the value of knowledge communities as safe places to explore conflicts between one's own practice knowledge and prescribed practice. I wonder if Dawn's ongoing involvement with peers in professional development activities while working in western Europe provided her with the opportunities she does not have to the same degree here to explore and contest messages coming through the conduit. I further consider Nelson's (2001) discussion of chosen communities nested inside found communities and the possibilities for narrative repair, for "resistance and insubordination", for developing counter-stories, that she sees in these

communities. I wonder if being part of a chosen community isn't some of what Dawn is missing as she looked backward to tell this story of islands and bridges?

⊙

Table-top activities: A lot of it is cones and repetition and pegs

Dawn told me about her practice on an inpatient neurology service when we first talked. She mentioned using *tabletop activities* as therapy when co-treating a client alongside a physical therapy colleague or a therapy assistant. As this wasn't a term I'd heard before, I asked her to tell me more:

> [D] [pause]. Yeah [pause] the, the activities that you can do in an acute care [laughs] are limited… [pauses].
> [S] Painful digging into this?
> [D] Not my best. I don't feel as holistic as an OT in this setting as I did in my previous setting in [Europe] for sure. So some of the tabletop activities–so usually the goal is kind of to work on fine motor, upper extremity, cognition, perception. [Pause] And so you can give the patient some writing activities – we have books with some exercises for cognition and perceptual exercises as well. So those are more the, so those are what we refer to as tabletop activities.
> [S] And for upper extremity?
> [D] It's not as functional as it can be. We do have some games that we can play with the patients but still a lot of it is cones and repetition and pegs, yeah – so it's not always as functional [pause] as we could be.
> [S] And that's the reality of practice is that you have to work with, within the system?
> [D] within the setting …

In this practice story Dawn is sharing what she is able to do when she works alongside a physical therapist or therapy assistant in this specific practice place. She remembers how she felt that what she did with clients was more

holistic and more functional when she was working in the extended care facility in western Europe. She mentions the specific skills and abilities that these tabletop activities are designed to address – movement, coordination, perception and cognition but not what occupations these skills facilitate clients doing in their daily lives. She comments that the activities are not as *functional* as she would like them to be. In this place, Dawn finds herself sometimes asking clients to stack plastic cones or put pegs into peg-board holes – "cones and pegs". Sometimes she may play a game with a client, but in that acute care place, more often it is cones and pegs, or workbooks with cognitive or perceptual exercises. While she is doing these activities with the client, the PT or rehabilitation assistant may be working alongside her with the client on sitting balance or other concerns; the client is simultaneously being asked to focus on balance and posture and on working with her/his arms and hands to do tabletop activities.

Turning aside for a terminological knot: Holism, function and functional

Before inquiring into this story, I turn briefly to talk about terms that occupational therapists use in describing what they/we do. *Holism* and *function* are loaded words in the OT language of practice. *Holism* is described variously, but could be summed up as the need for OTs to be aware of the whole person – mind, body and spirit – engaged in *doing* (Finlay, 2001, p. 269). Part of the therapist's oath that Dawn took in her country was to be *holistic.* Some of the people she most admires – an OT preceptor, OT

colleagues and some of the PTs she works with – are people she sees as working holistically.

Function and *functional* are ideas that appear often in Dawn's stories on the professional practice landscape. They are also commonly-used terms in occupational therapy, although the goal of being able to *function* has to some degree been replaced with being able to *participate,* in line with changes inside and outside the profession. *Function/functional* appear in many definitions of what occupational therapists do – for instance, occupational therapists ensure their clients can function in their ADLs, work and leisure. Function has to do with being able to do what one needs, or wants, to do. An example of how Dawn interprets function emerged when she was telling her cooking stories and she talked about the AMPS as being an assessment that is "*really functional".* To her, this approach to assessment is functional because it shows her what clients can actually do in situations that are as close as possible to their everyday lives. In another discussion she talked about playing Sudoku, an occupation she uses when she is feeling overwhelmed:

> [D][DP1] It's a way of kind of bringing things back to a basis that it's *functional*".

When she is stressed, and has problems doing what she needs to do, taking the time to play this game helps her to regain her ability to be able to manage her many life demands, to be functional.

I don't think we always do best by the clients

Returning from this terminological aside to Dawn's story of *tabletop activities*, I re-read the transcript and listened again to the tape of our initial one-on-one discussion. I wonder if this wasn't a moment where Dawn's belief that therapy should, or could, be occupation-based – and for occupational therapists, this is one of our sacred stories of practice (Crites, 1971; Hammell, 2009) – collided with telling me a story of what she was *able* to do with clients in that acute care place. After all – an almost universal shorthand used by OTs when talking about non occupation-based practice is "pegs and cones" – having clients do "contrived exercises" (Fisher, 1998) like stacking cones or placing pegs into a pegboard, or anything that the client does not see as having purpose or meaning – and she was telling me about using pegs and cones. Yet in this acute care place, and when working side-by-side with physical therapists with a client, perhaps Dawn's personal practical knowledge of doing occupation bumped up against *conflicting* stories (Clandinin and Connelly, 1995) of biomedicine. That may have left very little opportunity for Dawn to be occupation-based through finding ways to co-create meaning with clients while using these therapy activities. As Schell (2008, p. 178) notes, in discussing the pragmatic reasoning in which occupational therapists must also engage, therapists use the tools and equipment that are at hand in their practice, and work within many other constraints such as organization policies, time, and caseload concerns, within their practice contexts.

Dawn could have been living out an acute care story of practice that values efficiency, inter-disciplinary working and quick discharge of clients to home or to a rehabilitation facility:

> [D] The healthcare focus in an acute care setting seems to be on getting patients out, we need the beds. And I think as a result of that, patients sometimes get discharged too soon. [Pause] I'm personally right now feeling pretty comfortable because I kind of know what I 'm doing and get the job done, but it's from a health care perspective – I don't think we always do best by the clients.
>
> [D][DP1] The priority is discharge, so the minute you're independent in your ADLs you're going home, regardless of what your bigger life picture is looking like.

Dawn felt competent in this setting. She knew what she was doing, and she was getting things done. She felt comfortable with what she was doing, but she didn't feel comfortable with the priorities in that setting. She was aware that the clients were being discharged too soon, and that the focus on ADL independence meant that many other important big picture issues that clients had were not being addressed.

Thinking on your feet, putting out fires. I had that down to a "t".

Looking backward and inward to this place from where she works now, she said:

> [D][DP1] I do miss some aspects of acute care – I like the flexibility, the thinking on your feet, the putting out fires. I had that down to a "t".

She enjoyed the fast pace in that acute care place, and likes the variety that occupational therapy practice can offer:

> [D] And I think that's probably what makes you an OT because you are focused on so many different areas depending where your patient, depending on their deficits. You know, one day you could be looking

> at return to work, the next you're doing cognition. Then you're doing ADLs. Then you are doing family counselling. You know it's so multidimensional and you're so, you have to be so flexible in your approach and your thought process. I think that needs to be part of your personality in order to do that.

She reflected that this ability to focus on the varied needs of clients is part of why she enjoys being an OT. She thinks this flexibility and ability to help clients with diverse concerns are what makes occupational therapists who they are. This flexibility is something that Dawn sees as a required personality trait. Another way of viewing this is to think about stories to live by, that is, a narrative understanding of identity where identity is linked to personal practical knowledge and context.

We talked about differences between OTs who chose to work in different practice areas. Dawn said that working in acute care suited her style:

> [D] So I think acute care is kind of what fits me as a person at the moment.
> [D] Although, on the other hand, we do have OTs working in ortho where it's pretty set in stone, right?
> [S] It would be interesting to do personality surveys with OTs working in different areas of practice and see if there are differences. For sure there's some difference between mental health OTs and physical disabilities - even within those two areas I think it would be interesting to look at kind of personality traits…
> [D] Yeah, I think if I had to work in ortho, I'd have changed careers. That would be totally not me. I do like the flexibility and the changeability of the profession.

In addition to the ways in which this acute care place felt like a good fit for Dawn, she also really enjoys working with clients with neurological conditions:

> [D] I just love working with neuro patients so …

> [S] What's behind that love? What's so intriguing to you?
> [D] You never know what you're in for, and it is multidimensional. It's not as structured and there's a lot of problem-solving on the spot and the patients as well are just, they can be so interesting and different. Just to work with them and try to get them to where they need to go and try to accomplish that, trying to get them back into society, I think it's quite rewarding. Because it's so challenging for somebody who has all the neuro deficits compared to, like, a quad in a way. Yeah, they'll have the physical disabilities but they have cognitive capacities in order to make it happen, but to make that happen for somebody with a frontal lobe injury is quite different and it's a different challenge for me in a way.

In this practice landscape, Dawn gets variety, flexibility, a fast pace, the chance to problem solve, and to work with clients whose complex issues both intrigue her and fill her with compassion for the extra challenges they face in recovery. I think backwards to Dawn's stories to live by, of standing alongside of a young classmate to prevent him from being bullied, of including a friend's sister who had Down's Syndrome in their childhood play, as I hear her talk about why she loves working with clients with complex challenges to help them re-enter society. I pull forward her childhood stories to live by of inclusion, of helping others to be able to participate.

We were more focused on trans-disciplinary goals

Further inquiring along the social dimension into this story of the acute care place, I wonder how Dawn's options and decisions about how to work with her clients might have been influenced by co-treating with a physical therapist (PT). Dawn clearly has respect for many of her physical therapist colleagues. Looking back, she has positive stories of working with other team members from her experiences in her country where:

> [D] We identify a patient's goal or a family's goal. And then we, as a team, solve that problem. And if you, for instance, if someone had problems eating, you could do your assessments with an OT and PT and a nurse to kind of figure out how to best solve the problem.
> [D] So I think in [her country] we were more focused on trans-disciplinary goals at that point in time, whereas coming here it was more multidisciplinary.

In that practice place in western Europe, occupational therapists, physical therapists, and nurses routinely worked together to find out what client's or family's goals were, and worked on how they could best help the client, without being too concerned about distinct professional territories.

Moving ahead from western Europe to the acute care place where this story of tabletop activities is situated, Dawn tells stories of working with her physical therapy colleagues:

> [D] Yeah, it depends very much on the PT, first of all. We have one PT who's dual trained. So there's not that much of a difference [laughs]. If you are the patient though, that's the PT you want. Because she has a very holistic feel and a very functional focus and her abilities of translating a patient's presentation to functional outcome is incredible.
>
> [D] And then one that's a newer therapist as well, is lacking a little bit of that … She's got more of the PT brain. So she's more focused on, came from an ortho background, and maybe that makes a difference. So she is more focused on the symptoms and lacks a little bit the translation to the general scope of what the patient needs to be able to do.

One of the PTs that Dawn works with is someone who was educated as both an occupational and physical therapist – an option that existed in Canada up until the early 1970s. To Dawn, this PT is able to bridge the gap between both professions, to understand the whole person, and to link the signs and symptoms that the client presents to what that client might be struggling to

do in their daily lives. This PT is able to work in a more trans-disciplinary way. The less experienced PT may lack some of those abilities.

Turning aside for another terminological knot: multi-, inter-, trans-disciplinary working

Healthcare professionals talk about multi-disciplinary, inter-disciplinary and trans-disciplinary ways of working. Briefly defined, multi-disciplinary care has each discipline working with clients and using their distinct expertise with minimal consideration of how other professionals would be involved in care. Inter-disciplinary working moves beyond that to have a team plan where the professionals involved are aware of what other team members are doing, but continue to work with clients but only within their own professional turf or "toe-hold", as Dawn has called it. Trans-disciplinary working means working across professional boundaries, based on the individual and collective skills of the team and the needs of clients (Choi and Pak, 2006).

Returning from this terminological aside, I bend back to Dawn's story from Europe of what she names as trans-disciplinary working. In that practice landscape, the OT and the PT and the nurse worked together, both to understand the client's problems with eating and also how they as a team could help the client. Perhaps their practice islands were closer together and there were more bridges between team members?

When Dawn came to Canada, she found more teams working in what she saw as multi-disciplinary ways. In her acute care place in Canada, to

work with a dual-trained PT must have seemed like a welcome return to a way of working she was familiar with from her western European work place. Dawn says that this PT is *holistic* and *functional* in focus. Dawn has commented about how holistic two admired mentors - one of her professors and one of her early preceptors – were. She names *holism* and focusing on *function* as part of her personal practical knowledge, and values it when she sees it in others. Working with the young PT whose way of framing issues is very different from how Dawn reasons through what she is seeing and doing, creates some tensions. It is almost as if when working with the dual-trained PT in this Canadian-practice landscape, there is little distance between the two therapists, whereas with the other, she has to build bridges between her metaphorical practice island and the island this young PT inhabits.

In the acute care landscape, like many other places in healthcare, one of the messages coming from the conduit is that trans-disciplinary ways of working are preferred. From a system perspective, this press towards what has also been called "generic working" makes sense. In generic working, the intent is that any member of the team with sufficient skills can be called on to do what needs to be done at that time, without regard for their professional background. Looking at this message from the conduit with skeptical eyes, I wonder if what are most obvious as priorities to biomedicine, such as reducing the signs and symptoms of illness (Dawn works on "fine motor, upper extremity, cognition, perception"), become the only things team members have a mandate to do. I wonder if Dawn's use of table-top activities

reflects, in some way, her trying to live out being trans-disciplinary in the ways preferred in this practice landscape, sometimes at the cost of being able to hold on to her own preferred way, of doing occupation. Because of this press, perhaps there was little room for occupation when Dawn was co-treating a client with any of the physical therapists.

When practicing this way in this landscape, Dawn had no need of *cover stories* (Clandinin & Connelly, 1995), the stories that practitioners sometimes tell to obscure what they're doing when resisting a dominant story. She was doing what was expected of her in this practice landscape, was getting the job done, but talking to me about it was, perhaps, a bit painful as shown by the long pauses as she looked for words to describe *tabletop activities,* because she was admitting to a practice that ran counter to her sacred stories of holism, client-centredness, and being occupation-based that came from her OT education and her own stories to live by. Living out these dominant stories, she was not doing what she considered "doing best by the clients" although it may really have been the only thing she realistically could do.

This is the same practice place where some of Dawn's cooking stories were lived out. She was trying to use the occupation of cooking with her clients. Her cooking stories tell of the many barriers she tackled repeatedly to be able to cook with clients. She was doing what she thought she *should* do as an occupational therapist, that is, living out her stories to live by. I wonder if she felt she had to have a cover story when cooking with clients? Was she engaging in an underground practice (Mattingly and Fleming, 1994)? I

wonder if, in this acute care place, Dawn might have felt she needed to author a cover story so she could engage in the underground practice of using occupations with clients.

Healthcare is different because it allows that to happen

Dawn's story of tabletop activities bumps up against her stories of practice from western Europe. In that practice landscape she had opportunities that came from higher levels of staffing, from having a budget for supplies and equipment, and from a story of practice that, to Dawn, seemed more in line with her stories to live by both on and off the landscape. As she says of that place:

> [D][DP1] It wasn't institutionalized at all. So I really liked that part of it as well. Healthcare is different because it allows that to happen. There are better staffing levels. It's way more dynamic, way more interactive. Way more patient/client oriented than things are here.

In that practice place, even though she talks about working in trans-disciplinary ways, perhaps she felt she could more easily live out sacred stories from her occupational therapy education about being holistic, client-centred, and occupation-based. She would have had time, resources and the expectation that she was to find out about what clients needed and wanted to be able to do, rather than operating within an environment whose institutional narratives appear to be more about efficiency and quick discharge of clients. Thinking forward from this place to the acute care Dawn worked, I wonder – does working with the clients with neurological injuries she loves so much, with their unpredictability and multi-dimensional needs,

give her opportunities to experience being more dynamic and more interactive as an OT, even with the limited resources and institutional mandates with which she must contend?

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Making jewellery: I have a great productivity story

After sharing some of the challenges of working occupationally in the acute care place where she practiced during my initial meeting with her, Dawn seemed eager to share a more occupation-based story from her new workplace early in the first research group meeting:

> [D][DP1] I have a great productivity story! I have a patient who is a jewellery maker. So he has some real fine-motor problems, but on any of the OT assessments he scored just fine. And when you look at him move his arm he's perfectly fine, but in his mind, that arm is not. But on all my tests he is just bang on, right? I thought, "What do I do?" because he's still finding that he can't go back to work. So I asked him to bring in the tools that he needs to work on, so he did that a couple of times. The only thing that I know that resembles jewellery making is a penny. So we've been working with pennies. He's been bending the rim of the pennies, he's been shaping down the rim of the pennies, he's been cutting out maple leafs…
> [K] You were defacing the penny. [all laugh]
> [D] Yeah, I could go to jail for defacing the penny [laughs] but I figure that's probably the best material. So the other day he came in and he had two bags full, right, and I'm "what the heck?" and he has these cases full of stones. He's got these 8 mm diameter diamonds in there. And at one point he picked up this tiny, little mini, mini diamond and there were maybe about 20 of them in this case. I asked him, 'So, what would that be worth?' He says, 'Well, about $70'. So I'm like [makes calculating noise] – he probably brought in about $5000 worth of stones. I'm like 'never ever do that again!'
> [K] Was he doing better working at that really fine level?
> [D] He's setting these miniscule diamonds into a ring. He has to push over the metal to make sure that the diamond stays in and it needs to be a perfect little star. But you're talking about millimeter work and you can tell it's not a perfect star. So, in his world, it needs to be a perfect

> star in order to do a correct job. You can tell that it's still not normal for him.

There are many rich stories held within this practice story. In this new practice place where Dawn is now, there is a rehabilitation focus, and the possibilities of working not just on ADLs as in her previous acute care place, but also on work-related concerns. Her clients are either inpatients or outpatients and she is able to work with them over longer periods of time than in acute care:

> [D][DP1] Inpatients – 43 days length of stay. Outpatients, they're revamping the whole thing – a length of stay of 6 weeks for patients to come in and work on their goals. There's lots of leeway. It's discipline-specific. If I want to see a patient for 6 months I could. But they're getting a bit better about – it needs to be evident that the patient is still benefitting, that their goals are being accomplished.

Although some of Dawn's practices in this place are mandated, for instance the story that she shared of making muffins as part of a standardized assessment, she finds she has more freedom overall as an occupational therapist:

> [D][DP1] I find at the [new place] I have a lot of freedom to kind of determine myself with the patient what we need to work on. You know that whole collaboration, right? You do have those options more.

There she has the time and the freedom to work with this client who passes all the OT assessments, and who looks fine, but who knows he still isn't able to do what he needs to do to return to work. She was able to live out her story of client- centeredness, working on the goals that the jeweller identifies as being most important. She reasoned narratively to understand what the

client had done in the past, and what he saw himself doing in the post-rehabilitation future. In thinking about what she could ask the client to do that would approximate the activities he would do as a jeweller, she decided that she could use pennies – they are both inexpensive and a readily available source of metal. She asked the client to bring in his own tools, and they decided together that he would bend and shape the pennies, and use his jeweller's saw to cut out the maple leaves on pennies. In the past he had made pins from maple leaves cut out from pennies, so this was familiar, as was the common practice of jewellers using less valuable materials to practice technique.

> Dear reader: Because, by the time you read this, the Canadian penny may be no more, let me show you what Dawn's jeweller was working with, when cutting out maple leaves, at close to scale:

One of the other tasks that jewellers need to be able to do, is to set stones into jewellery. So the client brought in some diamonds. He was trying to put them into a setting and push down the prongs to form a perfect star, using his familiar tools and materials. This would be consistent with what had been happening in therapy up until this date, but the client bringing cases full of precious gems to the centre made Dawn nervous.

Looking backward from this story of the cases(s) of the jeweller, I see many links to storied experiences Dawn shared with me about her childhood, education, early practice, and her time in the acute care place. These include stories about risk, duty, and using real versus simulated activities.

If he's always been high risk, he's not likely going to change post injury

Inquiring into the story of the jeweller and his gemstones, and particularly her response to him bringing in cases of diamonds, I wonder about Dawn's stories of risk both on and off the practice landscape. Asking her client to bring in his tools from home entailed a certain amount of risk because they might get stolen. Perhaps she didn't anticipate the even greater risk that the client would not only bring in his valuable tools but that he would also bring in the materials that are, in his world, everyday objects but not something seen in everyday life in a rehabilitation setting. After all, one of the first things that people entering the hospital are asked to do is to leave behind or send home valuables so there is less risk of them being stolen or lost. Dawn's response was consistent with how institutions manage risk – "Never, ever do that again!" I see in it too a caring response to her client; protecting him from the risk of loss.

Dawn has worked in neuro–rehabilitation, both in her current practice place and in acute care. In these places, it is likely that Dawn has encountered many individuals who become clients following accidents while engaged in what might be seen as "high risk" occupations. I wonder if she might then have a slightly different perspective on risk than other occupational

therapists without those experiences? In her cooking stories she talked about having to be aware of the different lifestyles and backgrounds that her clients may have come from. She mentioned the association between certain neurological conditions and alcoholism. It is likely that she quite regularly hears stories from her clients of what some people would define as "risky" behaviours associated with addictions. She talks about a current client and says:

> [D][DP1]There is the background of the person that plays a role in that – if he's always been high risk, he's not likely go to change post injury.

In one of the research group meetings she talked about a YouTube® video of a young man who is paraplegic and was trying to be the first person to do a backflip in his wheelchair. She recognizes that this is consistent with this person's stories of who they are, even though as a rehabilitation professional she worries about the risk of further disability, or even death, for the young man in this video.

Thinking about this story and inquiring again into the story of the jeweller's gems, I think about differences in his perception of risk and her perception of risk, even given that problems with insight can be a common issue with clients with neurological conditions. Perhaps he did not see this as a risk? Perhaps he felt this was the only way to get close enough to what his real job tasks are to know whether he could do what he needed to do. Dawn was caught in the tension between wanting to help the client have a therapy experience that was as real as possible, and not wanting too much risk. Negotiating this tension meant she had to reason through how to modify her

therapy approach without damaging the working relationship she had with the client.

OK, I'm going to fail this placement but I'll try and have some fun

In Dawn's own stories to live by off the practice landscape, I wonder if I see a slightly different response to risk than in this story. Certainly it was risky for her as a child to stand up for her young classmate against bullying. Certainly it was risky for her to come to Canada to do one of her fieldwork placements, given that the healthcare system in Canada was quite different from that in western Europe, and that she would be practicing using a language other than her mother tongue. Of that experience, Dawn said:

> [D] The first day at [the Canadian fieldwork place] I thought, "Okay, I'm going to fail this placement, but I'll try and have some fun." [laughing]

She worried about the risk of failure, but at the same time, it was an adventure to try something new. Moving to Canada to practice as an occupational therapist was another risk. Moving from acute care in one practice landscape to rehabilitation in another also shows her willingness to tackle new challenges. Although we didn't talk about it much when we met, I also know that Dawn is a hiker and traveler. She was a member of a team of rehabilitation professionals from Canada who hiked up Mount Kilimanjaro in Africa to raise funds for rehabilitation services there. There certainly had to have been risks in that venture. She is currently studying for a graduate degree while working full-time. Looking backward and forward, it seems that one of Dawn's stories to live by is about being willing to take risks.

Going beyond her duty

As I inquire into Dawn's story of the jeweller, what I notice again is her willingness to go the extra mile. For her to be able to collaboratively develop therapy activities relevant to the jeweller's job, she would have had to both spend time talking to him in detail about his job and what he needed to do, but also spend some time researching the everyday work tasks and job demands of jewellers. This extra care and attention to knowing more about her client's occupation allowed her to think through how she could find a way to simulate some of what he needed to be able to do. This willingness to dig deeper, to go the extra mile to understand clients' stories to live by and their varied landscapes, this holistic view, is something that she admired in an early fieldwork educator and is apparent in many of her stories of practice. It is also something that she committed to as she took the therapist's oath when entering OT practice in Europe.

It wasn't real enough

In some ways this story of the jeweller stands in tension with Dawn's earlier story of using "cones and pegs" as therapy activities in acute care. It is more consistent with her stories from her country of going out into the community with her clients to shop for groceries for a cooking activity; trying to make what happens in therapy more like what happens in clients' daily lives. Looking backward from this story to Dawn's experience of trying to cook in the acute care setting where the unit kitchen "doesn't even resemble a real kitchen", it seems that she has more opportunities in this new place for

more closely attending to her clients' personal practical knowledge, and to her own. Here she can more easily live out her stories to live by. This gives her more leeway to plan therapy activities that directly address her clients' concerns. Here she is more able to attend perhaps to three elements that Pierce (2001) has suggested increase the power of occupational therapy intervention: appeal, intactness and goal fit. Her client is doing something that is part of his story of who he is (appeal), is doing something with the tools he would typically use and in a manner similar to how he would have worked in the past (intactness), in pursuit of his goal of returning to work as a jeweller.

Even though Dawn tells this story of co-creating therapy activities with the jeweller as a way of simulating his work through using real tools, materials and tasks, in this new place, there are also some "high-tech" tools designed to simulate everyday activities that Dawn can use with clients. Dawn sees a place for them:

> [D][DP1] You can put your patient into the VR [Virtual Reality] zone and work on a lot of things… You're getting a lot of data from the patient. Joint placement, muscle activation… It's another tool, right, a tool that you have in your bag, however much you use it.

She can learn a lot about a client's physical abilities using these tools and does use them. But, this is not what she used with her jeweller client.

He wasn't interested at all

Although she sees a place for these "high-tech tools", immediately after she talked about them, she told the story of a 20-year-old client, a

"skateboarder dude", she is also working with at this new rehabilitation place. She had attempted to use a "high-tech" tool with him. She hoped that this client, who experienced a massive stroke, might benefit from using the Wii ™ so that he could practice his balance and play a game, but as she said:

> [D][DP1] He wasn't interested at all – it wasn't 'real enough'.

And yet Dawn mentioned that this client had been out snowboarding while still in rehabilitation. She said:

> [D][DP1] But he's a skateboarder dude. I had no idea he would have been able to do that. His buddies took him out.

She was surprised given his significant physical limitations at that point that he was able to engage in this valued occupation. In telling the story, she was reasoning through why he was able to do this. She thought about not only his physical abilities but also the support he got from his friends:

> [D][DP1] It's the whole social aspect and the culture that's involved.

And she thought about who this "skateboarder dude" was in terms of his stories to live by:

> [D] [DP1] But if there's anyone who's going to be able to do it, it's him – he's got the attitude, spirit, and abilities to make it happen, he's motivated.

One of the sacred stories of occupational therapy is woven around the idea that it is crucial to consider the person, their environment, and how person and environment interact to understand people's occupations, and to use occupations as means or ends in therapy. I wonder if this story of the "skateboarder dude" and what he could do when engaging in a real and valued occupation, with the support of his friends and in combination with

his own storied experiences, resonates with Dawn's understandings from her professional education. I wonder if the jeweller's tools and cases were, like the friends and the hill to the skateboarder, critical to him being able to begin to re-live his story of himself as a jeweller? Hocking (2007, p. 23) talks about the Romantic ideals that made their way into early occupational therapy – the healing power of art and craftwork, of "skill, hope and self-respect emerging from hopelessness and despair." Is this story of the jeweller a Romantic one, linked to one of occupational therapy's sacred stories of transformation?

During one of the research group meetings, we talked about the story of Bonnie Sherr Klein, a well-known Canadian filmmaker who had a stroke just as she was in the midst of editing one of her films. Klein has written about being scolded by her occupational therapist for spending time editing her film during the weekend, and thus being too tired during the week for what she saw as the contrived activities and exercises her occupational therapist suggested. Dawn said:

> [D][DP1] I'm the opposite of that story. I had a client who sold spices at the market and I encouraged her to work on her farmers market work on the weekend and tell me how it went.

Working with her jeweller client, she was again "the opposite of that story." She used real tasks and tried to understand how it was going for him. He could not yet make a perfect star, but Dawn, as his occupational therapist, would support him in trying.

Pausing before going on

In this narrative account of Dawn's stories of doing occupation, I have re-told four stories, and inquired into these narratives within a three dimensional narrative inquiry space – looking forward and backward, inward and outward and at place. In this inquiry process, I have come to wonder about issues of difference, in/interdependence, client-centredness, holism, professional responsibility, the impact of place (and within place, objects) on practice, risk, underground practice, inter/trans-disciplinary practice and the sacred stories of occupational therapy. The impact of the social context, of messages from the conduit about how to practice, across and within different healthcare systems, and the way these messages affect availability of resources for practice, is also very apparent in Dawn's narratives of doing occupation. The pragmatic reasoning that Dawn uses in negotiating between what she thinks is "doing best by the clients" and the context within which she has worked is also evident in her narratives.

The following narrative account is of Margaret's experiences of *doing occupation* as she worked with clients who were moving from living on the streets into housing, and as she drew on what she knows as an occupational therapist to *do occupation* outside of her formal occupational therapy practice.

Chapter Five: Margaret

Introduction

In this chapter I introduce Margaret. Two stories of *doing occupation* during her career as an occupational therapist are re-told as I inquire into her experiences. Using the three-dimensional narrative inquiry framework as a guide, I travel backward and forward exploring temporality, inwards and outwards to inquire into sociality, and view a variety of practice landscapes and places within Margaret's stories. I look for continuities and discontinuities in how Margaret is *doing occupation* and how her stories to live by and her personal practical knowledge bump up against other competing or conflicting stories, both on and off the healthcare landscape.

Introducing Margaret

Margaret is the most recently graduated of the occupational therapists who participated in this inquiry. I asked her if she would participate because I'd been taken with her stories of practicing in the inner city of a large urban centre. I had also been intrigued to see how she, like me and many occupational therapists I know, found ways of *doing occupation* to promote health even during times when she was not working as an occupational therapist. Working as an occupational therapist is one of two major roles to which she has committed herself since she graduated. She has also been a stay at home mother for a number of years. Since becoming a

mother, she has worked on a casual part-time basis on a geriatric assessment unit and in home care. She has a wide array of interests that have sometimes become work, and sometimes remained as volunteer positions, including being a council member for a professional regulatory body. She has organized a number of mountain adventure treks for groups of women and for families. It is this experience, along with her experiences of working in the inner city within a housing and harm reduction initiative, which will form the basis of this narrative account.

Margaret told me about her OT career, and shared her practice stories, both those when she was formally named as working as an OT and those where she was not, when we met for an hour and a half at my home. She knew me and two of the other participants through some collaborative work done in the past, or that is still ongoing. Margaret attended all three research group meetings, and made and shared two collages during the final session that she attended with one other participant and myself.

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Being a part of really basic needs

Margaret went into occupational therapy after entering university to study psychology. She had always been someone who was really curious about other people. When I asked her what had initially drawn her to study psychology she said:

> [M] I think just probably my curiosity about human interactions and the way that people cope with their (pause) motivations and self-consciousness and how they go about being in the world. I'm really, I'm

> a highly inclusive, highly extroverted, communal person – relationships are everything to me. I'm an ENFP, right? (laughter) I'm a beep, beep, beep, I'm like a little radar all the time.
> [S] It's nice to have that radar.
> [M] I am hyperaware of everybody all the time so it's just, to learn more about all the people. And to learn more about what derails people's lives. I guess, when I was young I probably would've looked at it that way. Because there was a sense of difference, but not that much difference. You know, there was still a humanity there that I wanted to understand, about how those people got to be who they were with those symptoms….

She tells a story of herself as an extroverted person who is highly sensitive to people, relationships, and environments, and is intrigued by what motivates others, how they see themselves, and how people might have come to where they are at the moment at which she notices them. She encapsulates this understanding of herself with the Meyer-Briggs (Meyers and Meyers, 1980) label – *ENFP*, which stands for *extroverted*, *intuitive*, *feeling*, *perceiving*. Margaret says that when she was young, she might have identified that some of what she saw as she curiously looked was people whose lives had gone badly off the tracks. Even then, though, she had some understanding that people are people, and that we are more alike than different. Margaret was curious about people's stories, how they had come to be who they were, and in the situations in which they found themselves.

Margaret transferred from studying psychology to occupational therapy after her second year of university:

> [M] My early exposure to psychology left me frustrated because I felt like you had to, that you were judging people. You were learning about and studying them and then judging them… you know, tucking them neatly into diagnoses, but we weren't doing anything.

While Margaret was interested in learning more about people, she ultimately wasn't comfortable with the approach that she saw in psychology, which she perceived as being focused on studying and judging people, rather than doing something to help them. As someone who liked to *do* and to *help* and who had already by that time been involved in being a camp counsellor, Margaret was dissatisfied with the hands off and superior stance she perceived as being part of psychological practice, based on her undergraduate exposure to the profession at that university and at that time.

This is me, my core

Through friends, she met some students in occupational therapy, and had the sense that this profession might be more compatible with her interests in mental health and in practical doing than psychology was:

> [M] As I learned more about what OT was about, and I learned more about the fact that you could be a mental health practitioner, that very quickly made me feel like it would be a good fit.

As she learned more, Margaret could see that in occupational therapy, she could live out her story of being someone who helps others, and be able to work with people with mental health concerns. A memorable course was one in which students conducted interviews while being watched by their professor and classmates through a one-way mirror:

> I loved (strong emphasis) that course (laughter). I love interviewing. Still, to this day, I've always been someone who loves public speaking and just being one-on-one with people and working with them.

This course was one at which she excelled, and gave her opportunities for doing things she still enjoys, talking with, and to, people either individually

or in groups. In her final year of undergraduate studies, Margaret developed a personal mission statement as part of a course assignment:

> [M] I remember sitting at my makeshift desk with tears running down my face while I completed that mission statement. It was one of those *ooooh* moments (laughter) where I had been working on it and I felt very strongly about doing it and it came together. I called my father and I read it to him on the phone. I said, 'I just wrote something that is me! This is me, my core.' And I don't think that changes very much.

Margaret's mission statement reads:

> I am a person who seeks to invest something of myself in the experiences of others. Through my various roles, as a therapist, an instructor, a companion, a parent, a learner and an earth-lover, I will wind my enthusiasm into the creation of active, satisfying lifestyles. I aim to open hearts, cultivate self-esteem, and listen closely to the voices that answer my endless questions. I want to fill each day with hard work and well-earned play. As years begin to pass more quickly, I would like to feel that I have recognized the significance of my individual life and have exerted effort to make it an extra-ordinary one.

As Margaret says:

> [M] That's what my mission statement was. And that's funny because you know, that mission statement was written in '97 and to this day, I've always used it on my resume because it still, it hasn't changed and I don't know if it ever will.

Margaret saw her mission then, and sees her mission now, as choosing to contribute to the experience of others, to support open-heartedness and enhance self-esteem and to listen intently and learn, as she asks questions. The curiosity about people that initially attracted her to psychology continues and is part of her endless questions. She values a lifestyle for herself that includes hard work, play, health and making a significant contribution. She hopes that through her hard work she will be able to create

an extra-ordinary life for herself through the various roles that she identifies as important to her doing.

Beyond the classroom, Margaret also completed student fieldwork placements that included, amongst other experiences, opportunities to work with adolescent offenders, youth in a "special needs" classroom in a high school, and individuals with addictions. She talks now about these experiences, in particular, opened her eyes to others' worlds and others' truths. These other worlds intrigued her and piqued her curiosity. She talks about the skilled mentors she met in fieldwork who helped her develop skills in therapeutic use of self, awareness of her personal boundaries, and safety when working with clients with histories of violent behaviour. She recognized through some of these experiences that her interpersonal 'radar' was useful, but not infallible, in the worlds in which she was finding herself travelling as a student.

What I had to offer was about dignity and stability

Margaret has worked in a variety of settings as an occupational therapist but:

> [M] The most important clinical OT position I ever had, the one that meant the most to me, that I felt best in, was the one at mental health residential services. I was the only OT working in mental health housing.
> [M][DP1] That's definitely the work that's my passionate interest, like marginalized populations and working with that.

Margaret sees this as the occupational therapy work that was the most engaging for her. As the only occupational therapist in this position, she had

an opportunity to address the most basic needs of individuals who had been pushed to the social margins of that urban centre. Often working within a harm reduction model, Margaret was the person who:

> [M] … Did the intake assessments for any of those individuals who were moving into those vacancies, framing up their support needs and the resource needs for them.
> [M] We're talking basic needs here.

She would work with these individuals to get them into more secure housing, and to possibly arrange for a peer support worker and other essential basic resources.

> [M] I got to the point in that position where what I had to offer was about dignity and stability and that's just about it. From there …
> [S] Yeah, the base of Maslow's hierarchy of needs…
> [M] Yeah, there was the potential to, and it still didn't always happen. But it still happened probably rarely, sustainably, but it was so significant when you could effectively, appropriately and caringly transplant someone or allow them to transplant themselves with this Supports for Independent Living [SIL] grant and a support worker, to a place they wanted to be. It was tremendously gratifying to me to see the potential for a life shift to happen.

Margaret's work was to put in place a support system that might provide the foundation for her clients to have stability, have their basic needs met, and from there, perhaps, make other changes in their lives. A story Margaret tells of a young OT student who came to do fieldwork with her provides a picture of what her daily life in that place looked like:

> [M][DP1] This was a student from the Maritimes. This young guy arrived and he'd gotten in OT because he was interested in worker's comp, because his Dad worked in the mines. I said, 'Just come with me on a tour the first day.' And his eyes are like this. His eyeballs were just huge. He said, 'I didn't actually think this happened in real life, I thought this was just on TV.' He watched me for many a day but by the end of that eight week placement he was driving my truck, he was

> downtown in the single men's hostel, moving guys out, loading up their stuff and cleaning things up and helping people go into supported living situations.

In this work she drove into the inner city in her truck, moving her clients' furniture and belongings, helping them clean both themselves and their rooms up and moving them into more secure housing environments. By the time she took a student on, this had become something she did routinely, as scarce housing resources became available. But it was a shock to her young student at the beginning of his placement.

I feel like Santa Claus

What she describes as a turning point in her career happened early in this work:

> [M][DP3] We were doing interviews together; I was still a pretty young therapist at the time. And I was getting more and more excited as this went on. That's what my instincts were. We had this, it was disgusting really, we had fifteen spots, and we probably had 3500 people on the wait list. Mental health workers across the city had come together to decide who should even be considered for these positions. We were really doing these interviews just as screening. We really hoped we wouldn't have to screen anyone out. We were screening for pimping or people who were heavy drug dealers that we realized we couldn't be able to accommodate in that environment. Probably after half a dozen of these interview I said, 'Beth, this is just so exciting, I feel like Santa Claus. It feels like Christmas to me!' And she turned to me and said, 'Margaret, I feel like God, and it's making me sick.' I was like, 'OK – I am not seeing this properly, the reality of this and what it means and who these people are and how they live within their worlds. The way that their occupations and their life unfolds is completely reasonable and normal and there's no judgment here. And who am I to see myself as having power in that situation?' That was one of my, 'Oh my gosh, I've got to think differently about this job' moments.

This powerful moment made Margaret realize that she had been thinking of what she was doing as distributing largesse rather than making god-like decisions that would change some people's lives and leave others struggling in the same difficult situation in which they currently were living. She had been excited about being able to hand out the gift of a place to live, even while acknowledging the impossible situation of only having fifteen units and thousands of people who needed housing. It was only when the nurse with whom she had been interviewing turned to her and offered an alternative interpretation, that they were playing God and it was sickening to have to do so, that Margaret realized what she had been thinking. Perhaps this was a moment when Margaret began understanding that, in this job, she needed to stop seeing herself as a powerful individual with gifts to give, as a *helper*. Perhaps this was a moment where she moved somewhat away from her sense of being really curious about other people, to starting to see herself in relation with them. As her perspective began to shift, she started to understand that, for the individuals with whom she was working, the occupations they engaged in were a reasonable response to the situations in which they found themselves. It was a moment where she started to see herself and her judgment of others and their doings differently. It was a moment when she started to think about power in a different way.

Inquiring into Margaret's story of meeting basic needs

Early stories to live by, a mission statement and a movie quote

As I inquire into Margaret's stories of the work that she sees her most important clinical work, I am drawn to her description of what she says is one of her early stories to live by. Looking backward, she remembers as a teenager reading George Eliot's (1871) quote: "What do we live for, if not to make life less difficult for each other?" As a young woman, that commitment to helping others was realized in her work as a camp counsellor. As an OT student, she spent several months as part of a medical outreach team working in Guyana. This story of helping seems to have been present early on in her OT work on the mental health housing team, trying to make life less difficult for the people with whom she was working. Travelling forward from that time and place, she has continued to live out this early story of helping others. She has volunteered at a community kitchen for low-income pregnant women. She has been a cook for a family in transition and supported women during pregnancy and post-partum as a doula. Margaret says that her mission statement is a further elaboration of that early story to live by, one that articulates more about how she goes about making life easier for others, in the context of the many roles she inhabits in her life. Making life easier has been, for her, often about helping people meet very basic needs – healthy play, basic healthcare, a roof over ones head, basic self-care, finding a person with a truck when one is moving, help with cleaning, journeying through pregnancy and early motherhood, needing something nutritious to eat and someone to share a meal or a story with. Her choice of occupational therapy as a profession has given her many opportunities to *help* and also the chance

to explore other stories of practice that go beyond the benevolence of a being a helpful gift-giver.

Margaret shared that this early story to live by, and the mission statement she developed as an occupational therapy student, also connects with a scene from one of her favourite movies, in which one of the characters says:

> I believe if there's any kind of God it wouldn't be in any of us, not you or me, but just this little space in between. If there's any kind of magic in this world it must be in the attempt of understanding someone, sharing something. I know, it's almost impossible to succeed but who cares really? The answer must be in the attempt. (Linklater, R. 1995)

As Margaret says:

> [M][CM] It's about sharing, that's all there is.

This quote says less about helping, and more about the value of trying to understand another person, of sharing who we are with each other, even when that attempt may not end in success. I wonder if it might live in tension with her earliest story to live by of making life less difficult. One story is perhaps more about being a powerful helper, the other about being in relationship with, of walking alongside, people that we meet.

Graduate studies: To learn a whole lot more about the big picture

As I look forward from this story of Margaret's work in the inner city, I consider what she told me about what she learned in her graduate studies. Her programme had a focus on disability studies:

> [M] I wanted to have the opportunity to learn a whole lot more about the big picture. I really like the way that that program was situated in the grassroots of the disability movement, because I had done all that

> work with peer support and consumer involvement initiatives. So it was a very good fit for me that way.

I wonder if Margaret's graduate studies gave her the chance, after seeing her clients *big*, to question the systems in which people's lives were lived. Even though she refers to this as the 'big picture' perhaps this was her chance to *see small* (Greene, 1995), to move towards seeing things from a system perspective, to interrogate the institutional and social narratives associated with homelessness, mental illness and addiction. One course asked her to consider the medical, social, and personal narratives associated with medical conditions. She looked at the social construction of narratives about post-partum depression. A social justice course was also something that Margaret looks back on as being very meaningful for her. Perhaps this was another chance to see small from a systems lens and to see how marginalized individuals' stories can both get lost in these systems and be the impetus for change.

Becoming an ally

One course that was particularly memorable to Margaret was based on the work of Anne Bishop, a social activist:

> [M] The case management course was the course where I got introduced to the concept of becoming an ally, and that book by Anne Bishop. That was really significant for me. That book, there are portions of that, that come closest to explaining how I am capable of interacting with people. I know this sounds like a weird thing to say, but communing with people has been something that has been present for me since I was young. I was awkward in it when I was young. As I grew more comfortable in it, I still couldn't articulate to people how to be able to do that. How to effectively draw someone out, how to make someone comfortable, how to hold space for

> somebody to be who they are. What are the parts of that process? What they needed was to come up with tangible explanations as to, 'how?' And I felt like Anne Bishop does it in that book. So, the notion of becoming an ally and how you do that and the characteristics of that. In this case, it's how you dissect privilege and people's self-awareness of how they are situated in the world and their interactions. The power dynamic and the way that culture unfolds and the way that society and community work and then how we can transcend that. That was the beginning of not only understanding how, learning more about myself, about how I was capable of it, but also how to maybe articulate for others or to be able to more effectively demonstrate for others, how they could deconstruct some of what they were about or to work on those elements themselves. That was the beginning, that was the first time I felt that I had dialogue around that.

As I heard Margaret talk about this course and the idea of becoming an ally, I thought back to her story of feeling like Santa Claus. What she had experienced, in that moment of realizing that she was enjoying the sense of giving out housing units like Santa Claus delivering gifts, and what she didn't yet have words for, was the difference between operating from a position of privilege and of being positioned as an ally, walking alongside the individuals with whom she worked. It was this sense of seeing that mostly what she could do, like the movie character she remembered, was to try to understand someone, to try to share. Bishop put into words what Margaret had been trying to do since having that educative moment. Having words to talk about being an ally helped her to begin to understand her own privilege, as well as talk to others about privilege, and about how therapists align themselves with clients. It is part of the work she does now with students in classrooms and clinical places.

I wonder about empathy as I inquire into Margaret's stories. I wonder how she has been able to lay aside her own judgments, her own need to *do for* someone, to help, in favour of being able to *be with* and *do with*. She talks about having had the ability from early years on, of drawing someone out, of creating a space where they can be who they are. But as Davis (2005, p. 216) notes in discussing empathy, sympathy and altruism, empathy is a complex process that requires more than close alignment with the thoughts of others, which she labels as sympathy. It results from mental alignment, followed by "crossing over" into the lived experience of another and emotional identification, and then by the return to self which results in both fellow feeling or sympathy and a deep understanding of the other at an emotional level (empathy). I think again about how this process and Lugone's idea of 'world' travelling seem similar. I think of Lugone's (1987) encouragement to do the difficult work of moving from 'arrogant' to loving 'perception.' I wonder if, as Margaret worked in that inner city place meeting basic needs, was she learning how to 'world" travel? Was she starting to experience what it was to do her work using loving perception to see her clients and herself?

Epistemologies: Erase the idea that there's one truth

A graduate course on research introduced Margaret to the concept of epistemologies, to a deeper understanding that there were many ways of knowing and many truths, which is something she now talks about with students with whom she works:

> [M][DP1] I talk about the notion of truths – my truth and it's *your* truth and it's *your* truth. Erase the idea that there's one truth.

She sees that each individual lives with their own truths, and that these truths are different than her truths. She recognizes that this idea of multiple truths is something that may be new or uncomfortable to some:

> [M][DP2] A new world in the sense. Many come from a very black and white view. There are many shades of grey. It's not rote. You have to be comfortable, too, expressing yourself through the ambiguity. So many truths.

Looking backward from Margaret's story of graduate school, is this notion of multiple truths something she started to learn as she worked with inner city clients?

> [M][DP3] I think one of the turning points in my career is realizing what occupation meant in different lifestyles, especially with marginalized lifestyles and stopping myself from trying to solve people's problems, or at least wanting to.
> [M][DP1] How can anybody reasonably engage with their occupations and feel anything that would include the possibility of not just living right now?

She had begun to realize that her view of what occupations meant to her might not be what they meant to her clients, that the possibilities she had because of her privileged background and because she was not struggling with getting basic needs met, were not the possibilities her clients may have had. It was the beginning of seeing herself not as someone who was there to solve people's problems, but to understand them, and from there to support people in the choices they made, even if those might not have been the choices she would have taken. It was the beginning of seeing that there are many truths.

In that inner city place, Margaret had watched as her student struggled with his judgments of the clients that they were working with, and came to new understandings:

> [M][DP1] This was good to see. That you can take someone who was just overwhelmed by the judgments that they hold inside themselves…
> [K] The community lays on them too.
> [M] They hold them for good reasons, not because they intend to have them. You can't help yourself with what you know. The exposure that he got in a really short period of time really changed him. Changed what he was open to.

She, too, was making that shift, understanding that she was not Santa Claus, and that she didn't want to be God. She was starting to become open to new ways of thinking and being.

Shifts in the professional practice landscape

As I inquire into Margaret's story of meeting basic needs, I also look outward to what was happening in the occupational therapy profession in Canada during the time in which this narrative was unfolding. The year that Margaret graduated from university as an occupational therapist saw the publication of an influential Canadian book on occupational therapy – *Enabling Occupation* (CAOT, 1997). The language of occupational therapy practice was changing from *helping* to *enabling*. The model of practice presented in the text was one that placed the client at the centre, and recognized the central spiritual core of each human being. This text introduced a process model for practice that started with identifying what the client felt were *their* issues in doing, not what the therapist identified as concerns. The process model also emphasized the importance of clients and

therapists identifying together what strengths and resources were available to each that would be helpful in addressing these issues. Implicit for the first time was the sense that both therapist and client had strengths and resources. This textbook built on earlier work about client-centred practice, but there was an even greater emphasis on collaboration with the client. The authors of *Enabling Occupation* were also concerned with issues of social justice and exploring ways to work that didn't lead to therapists' good intentions about client-centred, occupation-based practice being over-ruled within institutional settings (Townsend, 1998). I wonder if/how these new messages from the conduit affected Margaret's thinking about her practice.

They're forget-me-nots

Finally, as I think about Margaret's stories of meeting basic needs, I am drawn to one of the pictures she included on the collage pages she made in the final research group meeting. She included a picture of a bunch of small, brilliant blue flowers, growing amidst a pile of sharp-edged rocks:

> [M](CM] I think they're forget-me-nots. It's astounding the conditions under which they grow. The resiliency they have. They manage, they persevere. And they're beautiful in their own simple way. And they don't last for very long.

I cannot help but wonder if this image, this unforgettable image, is part of her story of practice, of meeting basic needs, and of coming to see how people manage, their resiliency and their beauty, the fleeting opportunities to understand, to know and be known that she began to experience in the inner city.

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Meaningful activity, skill-building and spiritual encounters

By no means could you dissect OT out of me

Almost all occupational therapists I know talk about how much they see the world as occupational therapists. They may have different words to describe this – 'using an OT lens', 'with my OT glasses on', or 'wearing my OT hat.' This way of seeing and being in the world happens both when occupational therapists are officially registered/licensed by a regulatory body and thus formally named as an occupational therapist, but also when they are not. Margaret defined herself primarily as a stay-at-home mother for eight years. In those eight years she did many things that she sees as having used her skills and knowledge as an occupational therapist. As she says:

> [M] Yeah, and that's what I meant about you can't take OT, and I say it off the record, by no means could you dissect OT out of me, it's not possible.

Mindful of the regulatory organizations rules about whether she can publically name herself as an occupational therapist during years when she wasn't on the official roster, Margaret found that her identity as an occupational therapist was indivisible from who she is.

Journeying together. Challenging self. Overcoming adversity

Given that, what did she do to keep on *doing occupational therapy*? One of the things she did was to organize and lead multi-day backcountry hikes in

the Canadian Rockies. She described these treks in an article published in an occupational therapy newsletter. In this article she:

> [M] … Talked about why that was occupational therapy, and what that was all about and I framed that all up in the article.

She started the article by making it clear that these trips were not formal occupational therapy ventures. In the article, Margaret talks about these trips with groups of women, or with families, as "an elusive mixture of meaningful activity, skills-building exercises and spiritual experiences", as "occupational therapy around the campfire." In one of the research group meetings she told the story of these trips:

> [M][DP1] I've created opportunities for groups of women, and family groups, to do backcountry trips to live a sort of simpler existence. And watch people come to terms with themselves, the level of maintenance that they require or don't require. And surprise themselves with what they're capable of and what speaks to them and all that good stuff.

In the article she shared, and in telling stories about these trips, it's clear that she was facilitating opportunities for occupation, and saw her role as a teacher of new skills. As trip leader she helped the people she travelled with learn how to pack their gear efficiently, read maps, pitch tents, and manage the "challenging tasks of grooming, hygiene and toileting in a raw and elemental world", or cooking over a camp stove. She describes the group esprit de corps that develops and the "informal, unfacilitated psychotherapy" that arises from situations and conversations as individuals and groups face the challenges and triumphs of the trip. The spiritual aspect is also something she describes as key in these experiences – finding meaning, being inspired,

learning more about self and others, being awed by the beauty of the natural environment, and enjoying opportunities for quiet reflection.

> [M][CM] There's something for myself, as someone who doesn't have a dogmatic faith in terms of a religion. The outdoor world is very much the spiritual world for me. The notion of being grounded in it. That's another element that I worry about for people in modern society. They are so disconnected from the natural world. There are so many children who have never done that. What does that mean, in terms of the fact that we are animals, and we are so far removed from that. I have yet to go with anyone into the natural environment and not have them be awed. They didn't have access or they didn't even know it existed.

For Margaret, the outdoors is the place where she feels most grounded, a place that is a source of her spiritual experiences. She knows that not everyone has access to these experiences, values these opportunities, and worries about what that means for society. One of Margaret's collage pages includes pictures from her back country mountain trips - both the picture of the forget-me-nots that I have already described, and a picture that shows a group of hiking boot clad feet standing in a tight circle:

> [M][CM] The notion of co-occupation - journeying together. Challenging self. Overcoming adversity. This is a picture of the feet of a group of women that I did a four-day backcountry hike with. So these feet have come a long way. There's been a lot of community built. The process of sharing stories, a large portion of occupation for me, is about shared story telling and understanding the uniqueness of everyone's story. And that there can be an immense amount of respect, in that every person in a circle has a unique story, that there can be a lot of respect for individuality, but we can still share.
> [K] It's a very deliberate pose.
> [M]It's a picture of group hug. We could only take that picture by cooperating.

Margaret sees the experiences of doing a backcountry hike as being a form of co-occupation. As the hikers travel together, overcome challenges and face adversity, a community is created. This community rests on shared

experiences during the hike and on hearing each other's stories. For Margaret, a large part of occupation is the stories that emerge while engaged in doing. These stories highlight differences as much as similarities. In this community each person is respected for their individuality. This community becomes one who can collaboratively do things.

Inquiring into back country hiking

As I read the article about these backcountry treks, revisit the transcripts and look again at the photographs on one of the collage pages Margaret created, I look backward and think about what she has told me about herself growing up, as a student and then as a beginning occupational therapist. I look inward to what she says about her own values and beliefs. I look outward to practice and research discussions within occupational therapy about the natural environment and it's impact on health.

I want to say, "Get outside!"

During one of the research group meetings, I asked the group about their own occupations, what they did to maintain their own health through occupation, and whether they ever encouraged clients to try out these particular occupations. Margaret commented that for her it has always been:

> [M][DP1] Gosh, it's the outdoors. It's just because for me it is so rejuvenating. I do have a very core belief that in our culture right now not enough of us spend enough time outside. In weather like we have I don't know if, unless you're raised to have the outdoors and being comfortable in it… Having the right gear is a part of that.
> [M][DP1] I have an image of human beings, like we're all being, all becoming like Gollum [a fictional character, who lives mostly in the dark and underground, from Tolkien's *Lord of the Rings]*. I want to say, 'Get

> outside! Even if it's just walking, anything, just get some fresh air. Get some fresh air!'
> I feel like it's part of basic health to breathe in the open, fresh air.

Margaret finds being outdoors restorative, and worries that, in modern North American society, people don't have, and take, the opportunity to spend time in the outdoors. I think about Margaret's mission statement, and her identification of herself as an earth-lover. I think about her story of being an instructor at a climbing gym after university. She has had these outdoor experiences, and does feel comfortable. For her, the outdoors is where she derives a feeling of being grounded, a connection with something spiritual.

I think about the choices that she and the hikers she travels with have, to go into the backcountry, with the equipment, skills and support they need to have a challenging experience that takes them out of their comfort zone. I lay this alongside her story of the clients she worked with in the inner city, who were outdoors and were looking for a roof over their heads. I wonder about the privilege that allows individuals the choice to do a trip where they might be cold and wet and dirty and through that experience learn what they do and do not need to maintain themselves.

What we do encompasses recreation therapy

Margaret told me the story from one of her student fieldwork experiences of having a recreation therapist tell her:

> [M] I remember the recreation therapist telling me. 'You should be a rec therapist.' I was thinking. 'How do I go there to talk to her about the fact that what we do encompasses rec therapy?' I have that memory (laughter) but I didn't want to do that, because I felt like it would be inappropriate. I can remember (pause) not having that conversation

> with her, but I can remember that I commented that she made a lot of sense. So I have an incredible repertoire of activities. I am a very outdoorsy person. I have often looked into doing Outward Bound and I never did. But I'm the kind of person who could've chosen to do Outward Bound instruction stuff. She could see that in me and she knew that about me while I was there.

For Margaret, her story of what occupational therapy is *does* include recreation, but in this place and time where she was a student she did not feel she could contest a staff member's identification of her as being more suited to being a recreation therapist. Margaret does have a lot of outdoor experience, has always been someone who spent times in the outdoors and has been intrigued by programmes like Outward Bound, which provide opportunities for challenging activities in the outdoors. She talks about also being fascinated with outdoors programmes for *at risk* youth. Margaret felt that the recreation therapist could see all of the recreation background she had, but could not identify that this was part of Margaret's chosen profession. Within that professional practice landscape and as a student, Margaret did not know how, or whether, she could contest the recreation therapist's view.

There are so few positions that allow for that

It had been somewhat difficult to incorporate these outdoor occupations into Margaret's work as an occupational therapist. When I asked her if she had used outdoor recreation occupations as therapy with clients, she said:

> [M] There are so few positions that allow for that in the way that they're structured, that I don't think I have very often. But I've certainly always seen engagement in recreation as being a healthy and important part of somebody's life. I certainly would have encouraged and given validation

> to that if it had arisen that it was something that clients did see as significantly impaired in their own occupational repertoire when they came to be with me in the various settings.

In other places where she worked briefly:

> [M] I remember feeling like that program was very well balanced, and that recreation and that notion of physical activity and health beyond; whole person health was a part of that. I can remember thinking that there would've been an opportunity if I had been there longer. The woman who I replaced for those 5 months was like me, she was off traveling somewhere, and I was a locum. I was back-filling for someone who was quite similar to me, older, but had a similar lifestyle. When I worked at the community mental health team I had a rec therapist working with me. So we were supposed to be working in partnership and it was a very challenging relationship. But that team certainly addressed recreation and leisure and valued that. They had somebody on staff that I collaborated with on things around that.

Some of Margaret's early career experiences did provide an opportunity to see how recreation and leisure could be incorporated into the activities offered to clients. One programme in which she was a temporary employee had some of what she was hoping to see, put in place by someone who she saw as having some shared values and beliefs about recreation and health. But Margaret was only travelling through herself, so was not perhaps able to build on what was already there. In the community mental health team on which she worked, recreation was acknowledged as important, but perhaps because of the conflict between Margaret and the recreation therapist there, there might have been some missed opportunities for her to do more.

Inquiring into Margaret's story of these mountain journeys that she led, I look outward to the occupational therapy literature. I think again about the Romantic ideals that Hocking (2007) identified as a continuing thread that runs through occupational therapy practice, one of the sacred stories of the

profession. In particular, I wonder about her discussion of the potential for extreme experiences to allow people to "transcend their circumstances and discover their spiritual essence" (p. 28). Margaret has told a story of the challenges that these trips held for some or most of the participants. Navigating with map and compass, carrying heavy packs, washing in ice cold streams, getting dirty, wet, tired, bug-bitten, sore – these are some of the extreme circumstances that Margaret and the people she hiked with have encountered. And yet in these short-term but extreme circumstances, she saw people beginning to see that they could cope with adversity, that they were resilient, that they could cope with challenges. Perhaps Margaret already had begun to partially understand this from her work in the inner city – that people are stronger than they think they are, that extreme situations often bring out strengths that might not have been apparent.

Although Hocking doesn't address this as directly, there is also a sense in Romanticism of the power of nature to inspire awe and evoke other strong emotions, and this is also present in Margaret's stories of these backcountry hikes. The spiritual encounters that she talks about come both from being in nature and from doing in the company of others. As I hear Margaret talk about the deep discussions that happen on these trips, I am drawn to her stories of being with, of trying to understand, from her work in the inner city.

I think about these trips and Pierce's (2001) concept of designing for therapeutic power. Pierce talks about strengthening the power of a therapy activity by attending not only to goal fitting, but also to appeal and intactness.

The appeal of being in nature for the participants who signed on for these treks and the very real work that was involved to make the journey speak to this being a powerful venture. Although these trips were not intended as therapy, what Margaret designed seems to have been powerful both for the women who travelled with her and for Margaret herself.

Margaret talks about the co-occupation that is experienced in these treks. Certainly there is shared physicality, emotionality and likely intentionality. I think about Margaret's mission statement, about what she says about "investing myself in the experiences of others", of doing things that are significant. Kuo (2011) takes a transactional view to explore how occupation can be a means to create experiences that matter. She describes the importance of therapists focusing on the gap between the present and possible futures, using occupations to create experiences that matter to individuals (p. 135). I wonder if this is what Margaret hopes will happen on these mountain treks?

Looking inward and backward, I see Margaret finding a way to bring her story of herself as an "outdoorsy person", as well as her personal practical knowledge of how to survive in these outdoor places, together with her stories of who she is as an occupational therapist. While this was not always, or even often, possible within her work when she was named as being an occupational therapist, it was something she found a way to do. Margaret told me of a friend she knows who is a fitness leader who leads adventure hikes for older women. She has been very interested in this

friend's work, and, although she can't see herself doing something similar as a full-time job, she sees herself wanting to continue to do some of these trips as a hobby. I think again about her mission statement as I see her hoping that these trips will "open hearts, cultivate self-esteem, fill each day with hard work and well-earned play." I wonder if, in travelling alongside of her mountain companions and the clients she worked with in the inner city, Margaret has found a way to become an open-hearted "world" traveller (Lugones, 1987) who works hard to pay attention to the *space inbetween* herself and the other travellers on the journey.

Pausing before going on

In this narrative account of Margaret's stories of doing occupation, I have re-told two stories, through inquiring into these narratives within a three dimensional narrative inquiry space – looking forward and backward, inward and outward and at place. In this inquiry process, I have come to wonder about issues of curiosity as opposed to compassion, helping as distinguished from being an ally, beginning to interrogate systems and ideologies through a disability studies lens, basic occupation, the impact of place on practice, how occupational therapists continue to *do occupation* when not named as working as occupational therapists, co-occupation, designing occupations for impact and the sacred stories of occupational therapy that arise from the profession's Romantic roots.

Chapter Six: Alegría

Introduction

This narrative account starts by introducing Alegría. Two stories relevant to *doing occupation* or, as she would say, *living occupation,* from her recent experiences as an occupational therapist and occupational therapy manager are re-told as I inquired into her experiences. Alegría has had a long and diverse career as an occupational therapist, however, the primary focus of this narrative account is on the work she has been doing over the last five years to help the therapists, therapy assistants, and the students she supports, work occupationally. Using the three-dimensional narrative inquiry framework as a guide, I travel backward and forward looking at temporality, as well as inward and outward to examine interactions between the personal and the social (sociality), to explore how Alegría came to practice in this way as a therapist and manager. The impact of place is also part of this inquiry. I look for continuities and discontinuities in how Alegría is *doing/living occupation* as a manager. I inquire into how her stories to live by, and her personal practical knowledge, lie alongside, or bump up against, other competing or conflicting stories in the healthcare and professional knowledge landscapes as she works with staff and students to shape practice locally and globally.

Introducing Alegría

Alegría is an occupational therapy manager, a mother, traveller, photographer, and volunteer amongst many other roles. She lives in a small western Canadian town not far from the Rocky Mountains. She graduated with a dual degree – in both physical and occupational therapy (POT) but has worked as an occupational therapist consistently following her first year practicing as a physical therapist. She has been a front-line therapist, worked in a private homecare practice, in a rehabilitation hospital, in mental health, with assistive technology, with First Nations communities, and is now a manager to thirty-five plus occupational therapists and therapy assistants working across a very large geographic area. She completed a masters degree in health sciences five years ago, doing a phenomenological study about the lived experience of receiving client-centred occupational therapy in a home environment.

While I have never worked with Alegría, our paths have crossed on a number of occasions and I have done a workshop for the staff she supports. I had heard about the work she was doing as a manager from a student who completed a fieldwork placement in the region and returned with excited stories of the initiatives underway there. Alegría and a colleague had offered a one-day workshop on *living occupation* at a national conference, however, I was unable to attend that session. She and her colleague have also presented their work during an online conference, talking about their own practice stories, sharing a client story, and talking about how Alegría has been

working with staff to shift practice to be more occupationally focused. I was able to attend that session, and also had access to a recording of the presentation. Alegría was the last person I interviewed, both at her home, and later, via Skype™. She attended part of one of the research group meetings via Skype™, as well as sharing a digital story about her practice, and occupational therapy job postings she had written. Alegría knew one of the other research participants from having worked for a short time with her many years ago, and another through shared connections with students.

As I've been thinking about writing this narrative account, it has occurred to me that what Alegría and I have been doing is somewhat similar. I am stitching together a basket that explores the experiences that participants in this inquiry have of *doing occupation*. Alegría has likewise been stitching and shaping a basket with the staff she supports in *living occupation*.

It was about the 93 year-old lady in her 100 year old house

About one month before I first met with Alegría in her home, she took a digital story-telling workshop. In this workshop, she used her own photographs, composed a storyboard, and ultimately narrated an approximately three minute long video about her practice as an occupational therapist. In her story she talks about entering practice in the early 1970's, and about how excited she still is about her work as an occupational therapist. She asks, "What is it about OT?" and then tells this story:

> [A][DS] For me it was the 93 year-old lady in her 100 year old house. She lived and slept on her couch. She could not move well. She did not want people to know how bad that was for her. She was worried that she would have to leave her house. I listened, I offered suggestions, talked about her wheelchair. I waited for her to make choices. She lived in her home for three more years. She died there. My thesis was dedicated to her. Over the years I have listened, laughed, and cried with people. It is about what they need to do every day. It is what they cannot do now and how my support helps them. In school I learned about occupation. At work, the clients are my teachers.

Alegría's story of this client speaks of her willingness to listen, to wait, to understand how much this client wanted to stay in her home, even though doing so meant that she was unable to access most of the house, and had to spend her days and nights in her living room. Alegría saw her role as offering suggestions, discussing choices, waiting for the client to decide, and honouring the client's choices. The client was able to live out her remaining years in her house because Alegría had been willing to listen and to advocate for the client. Occupation, to Alegría, is about what people need to do daily, and occupational therapy is about supporting clients to do this, in a relationship built around listening, laughing and sometimes crying together.

Inquiring into Alegría's story of the 93 year old lady

What might we learn through inquiring into Alegría's story of the practice? In this next section I will look backward and forward, to the personal and social, and to place, to try to understand this experience.

It is the conversations, the sitting together, that has built me

That Alegría's digital story, one that she now realizes is somewhat of a career retrospective has, at its heart, a client's story, is not surprising. Alegría

commented repeatedly throughout my discussions with her about the importance of hearing clients' stories in her practice:

> [A] One of the core foundations is the client's story.
>
> [A] I remember as a young grad, and also as a student. The parts of the learning that inspired me and ignited me were the people and the stories they bought to our interaction. Whatever setting, it really was their story, right from the beginning, that was what made me excited.

Looking backward from this experience, Alegría's interest in story was present from the earliest years of her career. She realized that she was not interested in being a technician, and that what was most important, and most exciting to her, was listening to, and trying to understand, clients' stories. As she says of her career as an occupational therapist:

> [A][DS] It is the conversations, the sitting together, that has built me.

Alegría worked for just one year as a physical therapist, and has worked since then as an occupational therapist. She talks about the opportunities as an occupational therapist she has, and makes, to learn about clients' stories. She says she gets teased about "just having coffee all day." She notes that:

> [A] The client's story is what you offer to the team. It is amazing how the health team gets surprised by that.

In her current work as a manager, she encourages staff and the students she mentors to listen to, and to think about, clients' stories. A very common request that Alegría has of staff is, "Tell me a client story." I think about what a good narrative inquirer Alegría is, in her attending to experience as expressed in story, looking both backward and forward, attending both to

internal and external conditions, and to the physical environments of her clients.

I think clients get it – being human *and* being professional

Alegría's story suggests that she is someone who is not afraid to laugh and cry with clients, to have a relationship that goes beyond the stiff professionalism that was part of her training as a student. Looking backward, she remembers being told that she must avoid showing emotion in order to be seen as a professional:

> [A] My professors were cold, stiff, had me in tears.

Alegría notices that other healthcare professionals may have been told the same story about professionalism and the need to be emotionally reserved. She tells a recent story of a friend undergoing chemotherapy, who had a quite distant physician. Alegría's friend brought the physician some fresh wild berries. That one act changed the relationship with her physician:

> [A] Her health for being recognized as an individual went up a hundred-fold. If that's what it takes to be recognized as a person.

Her friend was now being seen by her physician as a person, as an individual, rather than simply a patient. Alegría notes that this recognition is very likely to have improved her friend's health. The importance of these human connections and how they affect health is clear to Alegria, and is part of how she practices (in spite of the stories about professionalism she was told during her training). Alegría says that it is being human *and* professional that creates the conditions for clients to trust therapists, and to share their

deepest concerns about their occupations. It was her ability to be human *and* professional that allowed Alegría to enable her client to live and die at home:

> [A] One of my colleagues who is an amazing technical person, got only so far with this lady. It was about her wheelchair, and then all sorts of bad things were happening. So we decided I should go in.
> Then the story got even bigger. She was amazing. I wasn't judging her. I just wanted to know. She wasn't going into the kitchen. The lady across the street was bringing over extra food. I built a story of how she was living. It ended up being a team effort of supporting her, not judging her, it was her choice.

She states that a technical approach, even a skilled one, was not sufficient to understand the client, and can create more issues, in addition to those initially identified by client and team. Being human, being non-judgmental, lead to Alegría, and the team, understanding the story of how the client was living. With that story, the team began to be better able to support the client.

Alegría recognizes the challenges of working in this less distant way:

> [A] I think we need to build our capacity for that, dealing with the sorrow, the struggles and the joys. Things can easily get back to that distance.

Without learning how to deal with the intense emotions, the challenging emotional work of practice, Alegría sees that it can be easy to move away from being human *and* professional with clients to being more distant, more removed.

If you are the purveyor of hope

To Alegría, another part of being human *and* professional is to be someone who supports others in living in hope. Speaking again about her friend living with cancer, she questions why healthcare professionals could

not say something like, “Given what we know today, the evidence I have to date, you have three to five years to live,” rather than, “You have three to five years to live.” She says:

> [A] Why wouldn’t you just let them live with hope? I don’t think that’s bad.
> After all, what you believe and how you support yourself because of that belief, will really enable you to get certain places.

Helping students and new therapists learn how to be both human *and* professional at work is one of the things she now does as a manager. How do therapists sustain themselves, how do they continue to be someone who can offer hope? Alegría says:

> [A] I don’t know how many times, I’ll be asking them, ‘What are you seeing in this client?’ Let me go forward, let me come back, and be OK with silence and be OK with tears, and be OK with excitement.
> [A] In my mind it’s ok to cry with a client. What is really important, if you are the purveyor of hope, is the building up of self to be able to come forward with that energy.

Alegría talks with staff about how to travel alongside clients, to be able to move backward and forward, to be able to cope with silence, sorrow and joy. She helps the people she supports to learn to be resilient enough to come forward with hope, with energy to move ahead. Alegría thinks that therapists can learn this, and that this learning can, and should, start in university coursework that focuses on exploring client stories, understanding self, enhancing therapeutic communication and understanding relationship.

Being prepared to have choice; the courage to have choice

As I think about this elderly woman living in a house where she had to sleep on her couch, was unable to access her kitchen, and felt she had to hide

how hard this all was for her, I think about what Alegría told me about stories to live by from her childhood. Her mother was a single mother during an era when that wasn't common, and was a nurse. Alegría talks about how proud she was of her mother for pursuing her own path as a person, a nurse and a mother.

When Alegría was an adult, her mother chose not to report the symptoms she knew, as a nurse, meant that she had a form of cancer. By the time she did go to her physician, the cancer was very advanced, and there was nothing that could be done for her medically. Although Alegría was very angry with her mother at the time, she says that what she now realizes she learned from her was the importance of being prepared to have choice, the courage to have choice. She says that it has been very important for her since then to honour people with choices, even if the choices people make would not have been ones she would make. The importance of individuals being able to make choices that support their *being* is something she learned from her mother, both as a child and as an adult, and is what she carries with her now:

> [A] I'm almost in tears at the appreciation of what my mother gave me and what a good life I've had because of that. [Tears]

And with that knowing, Alegría was the person on the homecare team who was willing, and able, to work with this client as the client made choices about how to live, and die, at home.

Article after article, evidence after evidence; it's there, but we shouldn't let it stop us

Looking outward from Alegría's storied work with clients and staff, I am struck by her understanding of how the healthcare system works, and how she can affect change. As she says, there are many articles that discuss the continuing challenges of *doing occupation* within healthcare systems that are still largely centred in the medical model. Alegría is aware of that literature. She is aware of conditions in the hospitals and other healthcare settings within her region that influence practice. She doesn't only inquire into what is happening in these places, but also into the ways that she and the staff she supports might themselves be putting up barriers that make it harder for them to practice in the ways that they say they wish to. She notices that healthcare has changed, as more and more diagnostic procedures have been developed, and that the *doing of* these procedures has replaced interpersonal interaction in some settings. In her digital story, she talks about how easily help falls into the distance from a person, when they are seen as a condition taking up a bed, rather than as a unique individual with a story. When the person and the healthcare team are not connected, do not know each other, the help that is available falls into the distance rather than being where the person most needs it. The distancing that professionalism seems to require is something that Alegría contests. She wonders in what ways the system fails clients when it judges them, like the team could have failed the 93 year old lady in her 100 year old house.

Thinking about places on the professional practice landscape, she questions how places press for certain types of distant, non-occupationally focused working. In one setting she remembers having clients stacking cones. She reflects that she couldn't, at the time, think of what else she could do to achieve the same goals. From that experience, she wonders how the environment may cause therapists to be less client-centred and occupationally focused in their thinking. But she also notes that:

> [A][2] People say, you can't do occupation in acute care. It's not about the service. If you can stay focused on the client, you can't go wrong.

She notices, and attempts to dismantle, the barriers some staff put up to working with people in their homes rather than in hospital and clinic settings. She works with other disciplines (for instance, doing inservices with home care nurses in her region, talking regularly with referring physicians) to promote an understanding of occupation, and to look for better ways for teams to work together. She frequently inquires into the interactions between the system, her own personal practical knowledge of how to *live occupation,* and how the system and professionals working in the system create opportunities or barriers. During both my initial meeting with her, and in the research meeting which she attended via Skype™, she offered alternative perspectives to me and to other participants, for instance, contesting another research participant's views on prescriptive physician referrals for occupational therapy, seeing these as opportunities for dialogue with physicians. She appears to find ways to be able to contest the givens, and do so in a way which means she is heard, rather than simply seeing the

system as all-powerful. And because she was able to do so, she was able to honour the wishes of her client. And because she was able to do so, she has been able to help the staff and students she supports to begin *living occupation* in their practice of occupational therapy within this region.

⊙

Living occupation as a manager

Alegría is the occupational therapy manager for a large region that stretches from border to border of a western Canadian province. In this position, which she moved into about five and a half years ago, she works with occupational therapists and occupational therapy assistants in a large regional hospital, in small town healthcare clinics, and in homecare. Alegría had worked as an occupational therapist in this region prior to becoming manager. During my discussions with her, in her online conference presentation, and during the portion of the dinner party she was able to attend via Skype™, she talked about her experiences as a manager.

That was a pivotal moment. We had collective consensus

One of experiences Alegría sees as being pivotal occurred before she became a manager. Occupational therapists identified that they needed, and wanted, to have a way to better communicate and collaborate across the region. Interest groups, and later a *best practice* group mandated to look at occupational therapy practices in the region, came together. Two initiatives came out of these groups. The first, which was not implemented until Alegría

became a manager, was to design an initial occupational therapy assessment form that could be used by any occupational therapist in any setting across the region. The intent was that this document would travel with the client, so that the therapist in any part of the region working with a client first seen by occupational therapy anywhere else in the region, would be using the same document as the original occupational therapist. The other project the groups completed was researching, and choosing, a standard set of neurological assessment tools to use across the region. Alegría says it was doing these two projects in groups, although they didn't know it at the time, that created energy:

> [A] It was a pivotal moment. We had collective consensus on service. It was walking through these two initiatives together that helped us to get to the point where we were poised to use a collective approach to *living occupation*.

This turning point occurred when therapists in the region came together, either face-to-face or using telehealth technology, to work on these two projects, to develop something that they could all use. These projects, which were not explicitly about occupation-based practice, nevertheless gave therapists the experience of working together that prepared them for further exploration and development of shared practice approaches.

Actually just say the word occupation

When Alegría became the regional manager for occupational therapy she realized, partly through discussion with another local occupational

therapist who she very much admires for her occupation-based approach, that she needed to start, herself, using the word occupation:

> [A] One of my beginning things was to actually just say the word *occupation*. Reminds me of saying phenomenology. It took me two years to say phenomenology and yet it almost took me the same length of time to say occupation. What was I fighting; what was not right about it? I would offer that the medical model, when we define it as a barrier, is so ingrained in you, that you're hesitant to move to a language that you should embrace.

She says that she started to use the word occupation everywhere, even if the context wasn't quite right, even if she wasn't sure she was using it correctly. Alegría describes it as being more difficult than learning a foreign language, something she has experienced as well. As she says:

> [A] Because there's a context, a bigness to it. It's not like asking for a beer – *una cerveza por favor*.

She suggests that the medical model, if individuals let themselves define it as an insurmountable barrier, makes this change in thinking and language challenging. The ideas of occupation are very significant ones, and that, too, made changing how she talked about practice initially challenging. Still, after some time, using the word occupation just became easier. Alegría comments that it was important to her that her staff saw her trying, sometimes failing, but persevering, in learning something new, something important. As she says:

> [A] I would offer that, until we know our language, we don't know our profession.

Alegría sees some of the staff having similar struggles to those she had with language. She encourages therapists to talk with other therapists and to

members of the team using occupational language, and, more importantly, to use occupational language with clients. Likening it to learning a new language, she says:

> [A] If you can, talk Spanish with another Spanish person. If you can, talk and teach Spanish. We still get this, 'Well, I'll talk about occupation with the nurse, but not with the client.' 'Why? What's stopping you? Who's going to tell them about it? How did you learn yourself about words?'

Alegría's own experience with the challenges of this new language for practice, knowing that for her it was harder than learning any other new language she'd learned, allows her to both understand what staff might be going through in their learning, and to encourage them to keep trying.

Embedding occupation

Alegría's next initiative was to design a workshop with a colleague, called "Embedding Occupation", for all the occupational therapists and occupational therapy assistants in the region. In this first workshop, participants explored the use of occupational language, and learned more about an occupation-based assessment tool called the Canadian Occupational Performance Measure (COPM)(Law, Baptiste, Carswell, McColl, Polatajko and Pollock, 2005). Alegría's hope was that therapists would get comfortable with the language and with the tool. She hoped they would start to routinely use the tool in their practice as a means to becoming more occupation-focused. As she says:

> [A][CP] No one did it. But the language of occupation and reflection on occupation occurred and that is what needs to happen first.

Looking backward, she sees that she was still being influenced in her thinking by a medical model perspective that she sees as emphasizing the importance of tools in practice. She realized that:

> [A] It's not about a tool, is about how you look at things.

Alegría wonders if the emphasis on assessment tools she sees in students and new graduates isn't a reflection in some ways of working with a medical model perspective. She wonders again whether this emphasis on technical aspects, on assessments, is also another way of maintaining distance or not being emotionally involved:

> [A] I kind of feel with the advancement of technology, to be prescriptive, to have this test or that, the emotions went out too.

Thinking about language, she comments about the title of that first workshop, *Embedding Occupation*:

> [A][CP] How reflective of the medical model was that?

Embedding occupation into a medical model did not sufficiently challenge and empower the occupational therapists at that first workshop to become more occupation-based in their practice. Having a new assessment tool, even one that is very much designed to understand what clients' occupational priorities and concerns are, did not change the practice of occupational therapists in the region. Even when people used the tool, the documentation that followed did not reflect what clients wanted and needed to do, what their stories were:

> [A] That's the medical model. Let's use this tool, and then go ahead and do what *we* want to do.

She wondered if there had been a "huge disconnect" happening with therapists who wanted to be more client-centred using tools like the COPM (Law, Baptiste, Carswell, McColl, Polatajko and Pollock, 2005) which ask for clients to share issues and priorities, but then doing what they had planned to do all along, without adjusting their plan to address the needs and wants of the client. This concern came after having reviewed the documentation of some of the occupational therapists who had participated in the first workshop. So, having risked and learned, Alegría and her colleague redesigned the workshop, to focus on *living occupation.*

Living occupation

The next version of the workshop was, like the first, focused on helping therapists and therapy assistants reflect on, and learn to use, the language of occupation. Unlike the first one, Alegría did not plan the workshop with the intent of introducing a new tool. The workshop was renamed *Living Occupation*:

> [A][CP] Living is strengths-based and, like occupation, is meaningful to the person.

In these workshops, participants again explored the use of occupational language. Prior to the workshop, participants were asked to write about what occupation is to them, what meanings they ascribe to the word occupation. In the workshop, participants spent time discussing occupational language, and working in groups to use occupational language in revising job postings, a progress note, and a discharge note. It was difficult:

> [A] Everyone had profound difficulties. You have to walk through those challenges to know it yourself.

But as the groups worked:

> [A] They just got down to the nitty-gritty, struggled, and then they came out saying, 'That was the best experience for me, to try and learn that, to feel it. To put it to pen.'

In working with the documentation they used daily, they were starting to live writing occupational language. In these workshops, the therapists also reviewed the shared initial occupational therapy assessment form that had been developed earlier, and changed two headings – they replaced *problem* with *occupational performance issue*, and *plan* with *enabling processes*.

Alegría says:

> [A][CP]It's a simple change, however when each OT goes to write, they stop, reflect and focus on clients' occupation. It puts the client first, uses the language of occupation, so that we can enable living occupation.

Alegría and a colleague are now considering what their next step forward should be in supporting *living occupation* and what the next workshop might look like.

Celebrating you, building self

Another way Alegría has explored how to support living occupation is through doing performance reviews differently, narratively:

> [A][CP] It's through stories we build understanding and meaning.
>
> As she says:
>
> [A] In management I am further away from those stories. So I'm calling performance reviews 'Celebrating You, Building Self".

In these performance reviews, Alegría asks staff to tell her stories to demonstrate how they have implemented the values of the healthcare organization, or, now, how they have used the ten enabling occupation skills (adapting, advocating, coaching, collaborating, consulting, coordinating, designing, educating, engaging, specializing), as described in the Canadian Model of Occupational Performance and Engagement (Townsend and Polatajko, 2007) in their practice:

> [A] Say the client's first name, use a name, and tell me a story. These stories have inspired me, have brought me to tears.

She says doing this is about helping staff with:

> [A] Recognizing that you have it within you every day. You may have values that are more valuable than the [healthcare system's] values. Those ten enabling skills – you demonstrate them. You already have it; you just didn't have the words for it.

Again, Alegría is trying to support staff in *living occupation* through helping them find the words to describe their practice. She encourages staff to tell her what they've learned from the clients about whom they tell their practice stories. The challenge of taking the time to reflect on learning is something she acknowledges with busy therapists. She tries to help staff develop strategies for reflecting on their practice.

Inquiring into Alegría's experiences of supporting living occupation

As I inquire into Alegría's experiences of supporting staff to live occupation, I look backward to her stories of being a student and a clinician. For her, it has always been about stories and about interaction with clients. That is what she enjoyed as a student, what she missed working as a physical

therapist, and what she now enjoys about her work. She is competent in the technical skills of practice, but she sees technique-focused practice as unrewarding. She says, of leaving physical therapy practice to start being an occupational therapist after her first year working:

> [A] When I made the switch, I got the parts of the treatment that were important as well. At [rehabilitation centre] we did do basketry and woodworking. We were trained to do that. But that didn't really… it wasn't about the basket. It was about the person and I doing the basket.

She learned about doing together, the stories that are shared *in* doing together and the story that is created *by* doing together. Her experiences with the 93 year-old woman in her 100 year-old house, are about waiting, listening, hearing the client's story and honouring the choices the client made, things that were consistent with the client's story of who she was and wanted to be. I think about Alegría's story of how her friend who was undergoing chemotherapy, created a story of who she was by bringing wild berries to her physician, and how that changed the interaction between her friend and her friend's doctor by creating a new shared story and decreasing the distance between physician and client.

Given Alegría's experiences with doing together with clients, her own values about knowing clients through hearing their stories, it isn't a surprise that she encourages and supports staff to work at knowing clients through story. It is not surprising that she has transformed the performance evaluation meetings she has with staff to allow, to require, the sharing of stories.

She always demonstrated hope

I notice as I think about all the stories that Alegría has shared with me, how hopeful she is. She acknowledges the challenges of working as a manager in a system that is still largely based on the medical model. Sometimes she gets frustrated and:

> [A][DS] I can get angry. Hearing someone say, "Room 204 isn't eating" troubles me. Help easily falls into this distance from a person. Why?

It is this distance between the client and their needs, and healthcare professionals that often can mean that the help offered is not really what the client needs. This is sometimes something that Alegría gets angry about. Still, she doesn't let herself get discouraged very often.

I remember something Alegría said about hope. Looking backward, Alegría says that, in spite of there being very little family support for her mother:

> [A] She always demonstrated hope.

Even though her mother didn't have much family support as she went about raising Alegría, even though that meant some financial hardships, her mother was always hopeful. I think about Alegría's concern for her friend with cancer, that she be supported to continue to live with hope. I listen again the words of Alegría's digital story:

> [A][DS] Hearing the words of the client gives me hope, inspires me.

I think about how Alegría gains inspiration from one of her current colleagues, who she admires partly because:

> [A] She has an amazing heart and exhibits many, many, many – her wish is to always look for the possibilities and not the barriers. It can happen as an occupational therapist that you can see the next step, and the occupational therapist will be the person who steps forward. And she will do that with joy.

Alegría works with someone who focuses on what can, rather than what cannot, be. Her admired colleague is willing to be the person who is able to do what needs to be done and does it with joy. This colleague is someone who Alegría has worked closely with to design and run the Living Occupation workshops. She is someone about whom Alegría says:

> [A] She is committed to the client, will listen to the client, and that will guide her. She is a champion of the COPM. That guides her. That enables her clinical reasoning. She does it with joy. There's such a positive presence of enabling occupation. That it's a gift; that it's seen as a gift. She inspires me, pretty much every conversation we have.

I think about how important hope is, and hear Alegría gaining hope from her experiences with her mother as a child, and now from the people she works with, her close colleague who inspires her, other therapists and assistants, and clients. I consider the phrase *hopeful action* that I read recently when exploring the connections between Romantic ideals and pragmatism (Deans, 1999). I see in Alegría someone who takes hopeful action, and helps others do so as well.

No one asked her about risk when she was a rodeo rider

Inquiring into Alegría's experience of supporting staff to *live occupation*. I think about her willingness to try and to fall, and to try again. I think again about her story to live by from her mother, about being prepared for choice,

about having the courage to choose, knowing that not all choices will turn out to have been good ones. Her mother's choices about whether to seek out treatment early when she knew she had cancer, might or might not be seen by someone else as a choice they would have made, but Alegría came to see how important having and taking choice are, in spite of the risks. She told me a story about risk. An 80 year-old client was being assessed for fall risks in her home, and Alegría was thinking:

> [A] Here she is at 80 and she is not being allowed to take risks. No one asked that when she was a rodeo rider.

I see her consciously and publically taking risks:

> [A][CP] I stumbled. I kept trying more, so that my staff would be comfortable with it. More than being comfortable with it, I was modeling it was OK to try, OK to take risks.
> [A][DP3] You have to have a driver. I make mistakes. I don't think it's as hard as we believe it is. I think we create our own limits.

Alegría talks about the importance of being able to make choices to risk, to try, in creating a learning culture within her organization. She talks about getting everyone together in a metaphorical raft to run the rapids.

Lately, she's been seeing that there are other teams, in other parts of the zone, the province, the world, undertaking similar journeys:

> [A] Yes, we are a group learning about this. Part of what I wish to instill is that there are more of us out there. What's wrong with including everyone? So that's now our practice, to include all of the zone, the whole province. So by participating at a national conference, and now the online conference – we're modeling that you can make choices to get bigger and bigger and bigger, and learn and learn and learn.

She sees that there are other teams running similar rapids. So, in addition to reaching out to other occupational therapists/assistants in the zone where

she is manager, in the province and in the country, she is encouraging the staff she works with to see beyond their boundaries, and to keep on learning. In some ways, she is decreasing the distances between the therapists she manages and other therapists also interested in *living occupation*. In her willingness to choose to take risks, to reach beyond the boundaries of place, Alegría is creating opportunities for staff to see that what they are not alone in working on *living occupation*. I think about Cooper's (2012, p. 201) call for occupational therapists to move from focusing primarily on internal dynamics such as issues of status, definition of scope of practice, regulating entry into the profession, definition of levels of competence, protection of knowledge base, to an outward-facing dynamic that actively addresses public understanding of occupational therapy, providing economic evidence of the value of our services, developing leadership, and addressing issues around professional prestige, amongst other factors. Cooper (2012) identifies several areas of optimism in external dynamics: populations with complex issues, expanding areas of practice, interprofessional education and practice, use of social media, and developing political skills and advocacy. I think about what I've heard of Alegría's work and the work of the staff she supports. I see how strengthening internal dynamics can, and is, providing opportunities to get bigger and bigger and bigger, and learn and learn and learn. I see that she is attending to both internal and external dynamics. I notice, as an educator and inquirer, how Alegría acts as a bridge between the university programme closest to where she practices; providing

opportunities for many students to do fieldwork in the region, mentoring new graduates and expecting that the university will reciprocate in providing opportunities to learn more and to participate. I think about Baptiste's (2011) call to the profession to forge greater links between researchers and practitioners, and the recipients of occupational therapy services. I notice how Alegría pursues opportunities to do this.

Alegría has read about the participatory action research of Wilding and Whiteford (2007) in Australia on becoming more occupation-based. The research from Canada by Aiken et al. (2011) about the meaning gap that occurs when there are differences between practice as therapists think it *should* be and as it currently is, has also been helpful to her:

> [A] When I read it, we could have written it from our experiences over this past year. Before this, I hadn't heard of anyone journeying along. It is our experience right now. When you're trying to stay current, if you see something that you're doing, that's being written about as evidence, then it affirms what you're doing, that it's OK. Our profession needs to affirm that that's OK.

I turn finally, and briefly, to think about place. Alegría works in a place where therapists are widely dispersed. It is a place that can often have extremes of weather. Every day she travels long distances, as do the staff who work in home care. This is the land of the Blood and of the Stoney Tribes, of Piikani and of Siksika Nations; it is ranch and farm country, country with Hutterite colonies, it is "next-year country" (Broadfoot, 1988). Working in such diverse places requires the ability to be a world traveller, understanding cultures that may not be familiar to therapists who are also travelling into new territories in their practice, using new language, hearing

and telling new stories. In these travels, therapists are in community with clients, with colleagues, with people in places – turning to each other and turning to the future. I consider how Alegría uses technology to expand who can tell and listen to stories around the table, who she and the team can teach and learn from. I think about how Alegría supports her staff in travelling through these varied landscapes, *living occupation*.

> [A] We have learned occupation in terms of going to school. We administered occupation. And yet if you *live* occupation, it's everywhere, all the time.

Pausing before going on

In this narrative account of Alegría's experiences of managing for *living occupation* I have focused on a clinical experience she has identified as providing an example of enabling a client to keep doing what she needed and wanted to do. Using the three-dimensional narrative inquiry framework, I have inquired into this story, and into Alegría's stories of her recent work as a manager to enable staff to practice more occupationally. I have considered the importance of listening to client stories and thought about how skilled occupational therapists who *live occupation* are like narrative inquirers. One of Alegría's stories to live by is about the importance of being prepared to make choices, to risk; something she attends to both as a clinician and now as a manager. The importance of hope and the critical value of language also appear repeatedly in her stories. I note how she works to create community locally and globally, sometimes using technology to enable this, to support

learners and learning, and how she seeks connections between clinicians, educators and researchers.

This is the fourth of four narrative accounts. Continuing with the metaphor of a coiled basket, I will next choose beads to represent certain wonders as I look across the coils that make up this inquiry basket. I inquire into how these narratives lie alongside each other or how they may bump up against each other. I think about how this bumping up may open spaces for new learning.

Chapter Seven: Beads, bumping up places, and opened spaces

Introduction

As I finish stitching the coils that represent the experiences and the stories of each of the inquiry participants, their *narrative accounts*, I now turn the basket, and look across the coils I have stitched and shaped with the help of these four occupational therapists. Looking at the basket in this way, rather than along the lengths of the coil that represent each account, I notice certain stories that I want to mark for further exploration, given my inquiry wonders. I realize as I choose, that there are wonders I will not explore in this dissertation, but will leave for a later day. Using beads as a metaphorical way of doing so, I add more to this basket. I look at how stories lie tightly alongside each other, and where stories bump up against each other. I think about how the beads I choose will complement or contrast with each other, how they might magnify what lies underneath them or mirror the image of the person stitching them to the basket. I think about how bumping up places can create spaces for new stories to emerge, new learning to occur. I choose beads that mark four wonders: (1) about reaching for what is real, knowing about people in their own environments doing their occupations; (2) about identities; (3) about the complex issues that swirl around spirituality, philosophical underpinnings and about the heart, mind and soul (Wood, 2004) of occupational therapy and finally, (4) about the strategies the

occupational therapists in this inquiry have used to resist or to relocate when working within systems incompatible with beliefs, values and evidence they have for their practice.

After I stitch these metaphorical beads (symbolized in the text with this marker ⭘) into this narrative inquiry basket, I will turn outwards from stories to the occupational therapy literature to inquire into how these stories appear or are absent from the stories the research literature tells. I then turn back to the stories told in this inquiry, and think about how I might stitch these research stories and the stories of this inquiry together.

Finally, I will look at how what I have learned in stitching the coils of the basket, and the beads that I have now added, will transform how I see my practice as an occupational therapist, as an occupational therapy educator and researcher. I will discuss what my hopes are for how this inquiry might influence the systems within which these stories have, and do, live. Finally, I will provide some examples of how I might share what I have learned with students, other educators, clinicians, and researchers.

⭘ Reaching for the Real ⭘

I pick up several large and deeply textured beads as I think about Katherine's stories of wanting to work with what was *real* in her work in her practice landscapes. I stitch the first bead into her story of working with First Nations children and women as a student, where she bumped up against the realization that unless she knew what these clients' physical and cultural

landscapes looked like, she would be limited in her ability to understand and to be kind, to live out her story to live by she learned from her mother. This bumping up place created a space that opened her eyes to possibilities that she explored throughout the entirety of her career, of getting out of the hospital, clinic, or office to where her clients lived. I choose another bead to draw attention to Katherine's stories of the real work that clients did at the not-for-profit agency, and the work simulation tools there that she didn't find helpful. Another bead marks Katherine's stories of working in home care, where she was in her clients' houses, as a guest, seeing what they could and couldn't manage there, and what they did or did not need for support. I note that this wonder about *real versus simulated* was something Katherine continued to explore through the research project she chose during graduate studies, so stitch a bead to mark her stories of graduate education. I choose one more bead to draw readers' attention to Katherine's stories of her medical-legal practice, to her idea of that work requiring travel to parallel universes, so she could understand what people really needed to be able to do in their worlds, as mud-boggers, sled-dog racers or birdhouse builders.

Looking at Dawn's practice stories, I pick up a bead that I stitch along the length of the coil that represents her inner-city experiences in her country of going out into the community with clients to buy groceries, to see how people dealt with the challenges of busy streets and stores. I think too about her stories about what the units in that place looked like, their hominess and the attention paid to what people's routines and roles had

been before entering the facility. I pick up another bead and stitch it where it will draw the eye to Dawn's stories in acute care of having artists draw, knitters knit and soccer players kick a soccer ball. Next to this bead, I stitch another bead, large and heavily textured like the previous bead, but looking like it has been squeezed, to mark a wonder about "tabletop activities", where it was difficult for Dawn to hold onto the real while working directly alongside another healthcare professional in an acute care place. I stitch another bead to represent Dawn's efforts to be able to access something that approaches a real practice kitchen in that acute care place. Another bead draws the eye to Dawn's assessment practices, to her concern about the ecological validity and fairness of contrived assessment tasks done in unreal places. I pick up another bead to stitch alongside her story of the jeweller and her efforts to co-design therapeutic activities that were as close as she and her client could make them to the real tasks he needed to be able to do in his work. As I stitch I think about co-occupation. Finally, I stitch one more bead to represent the story of the skateboarder dude who didn't find the game-based simulation she offered him real enough, but went out with his friends and conquered the hill.

I pick a bead to mark Alegría's stories of asking clients what they need and want to do, listening and honoring the choices clients make. I think about the 93 year-old lady in her 100 year old house. I choose another bead to mark an early practice story of having a client stacking cones, knowing that this wasn't how she wanted to practice, but not being able to determine at

that point what else she could do. What opportunities for learning did this bumping up place create for her?

I pick up two more beads to represent the tensions between real and simulated occupations in Margaret's practice. In her early practice, she found some, but not many opportunities to use real occupations with clients, and some boundary disputes with recreational therapy when she tried. I stitch a bead to mark this bumping up place. What space did this bumping up create? Once Margaret started working as the occupational therapist for mental health residential services, Margaret's practice world changed dramatically. In the places in which she travelled for this job, she saw real occupation, real basic needs, up close, and came to understand that some of the harmful occupational choices individuals made were reasonable responses to the situations in which they found themselves. I stitch a bead alongside this story as a reminder to consider the breadth of occupations, and the real basic needs that these meet, that occupational therapists will encounter in practice. Looking at this bead, I think about how these client stories to live by bump up against assumptions that arise out of the world of privilege from which many occupational therapists come. Both Katherine and Margaret commented, in some way, on becoming aware of the gap between what they knew from childhood and the "parallel universes" (Katherine's term) to which they needed to be able to travel. Hammell (2009, p. 8), in particular, reminds us that occupational therapists, and occupational therapy theorists, are part of a minority population (Western, "first" or "developed" world), and

that our assumptions reflect our own, limited, viewpoints. This gap is something that future inquiries could address.

As I think about the stories of these four occupational therapists' experiences with real and simulated occupations in assessment and intervention, I turn to the literature to ask what it says about real and simulated occupations in therapy. Nelson and his colleagues (Beauregard, Thomas and Nelson, 1998; DeKuiper, Nelson and White, 1993; Hall and Nelson, 1998; Hartman, Miller and Nelson, 2000; Zimmerer-Branum and Nelson, 1995) have explored the impact of using real materials and tasks versus rote exercise and imagined tasks and shown that there are differences in participants' movement patterns, memory, willingness to participate, and perseverance. Townsend's (1996) institutional ethnography showed how institutional factors such as space, time, treatment approach, and funding shaped therapists use of simulated activities rather than occupation with clients in a mental health setting (p. 126). She suggests that therapists can shift practice through changes in how occupational therapy is described and organized. She also recommends changes in recruitment and education of occupational therapists. Finally, she emphasizes the importance of research into the use of real occupations. Although Nelson (1997), Townsend (1996) and Trombly (1995) called for further research into the use of real versus simulated occupations in therapy, there are far fewer recent studies about this in the literature than might be expected. Studies of occupation-based practice (Price, 2003, Price and Miner, 2007; Ward, Mitchell and Price, 2007)

suggest that occupation emerges in therapy, as therapist and client co-create the meaning of what they are doing in therapy. Pierce (2003) and Pikens and Pizzur-Barekow's (2009) exploration of co-occupation, along with Mattingly's (1998) focus on healing dramas and clinical plots, provide some new perspectives on how somewhat contrived activities can become occupations.

A related thread of discussion concerns ecological validity in occupational therapy assessment. The discussion about *top down* assessment looks at how using real or close-to-real tasks in familiar environments helps therapists better understand if and how clients are able to do what they need or want to do. Douglas, Liu, Warren and Hopper (2007) found that Canadian occupational therapists reporting they used "*top down*" or functionally-focused assessment tools and approaches, for instance the Canadian Occupational Performance Measure (COPM), did so because: a) they felt the information gained by doing so was relevant to the team, client or family; b) they were familiar with the tool; or c) it was congruent with their theoretical stance (p. 376), believing that information gained this way allows for more client-centred and occupation based practice (p. 379).

As I examine these beads that mark the stories of *real* and *simulated* occupation as opposed to contrived activities, I look also for occupational therapy research describing the experiences of practicing in the community, in the real day-to-day worlds of clients, away from the parallel universes of hospital and clinic. Ramsey (2011), for instance, notes that little research has

been done to explore the experiences of American occupational therapists working in the community, in spite of an ongoing interest in role-emerging practice. Her research suggests that therapists working in the community see many positives of this work, such as autonomy, opportunities for creativity and greater client motivation through being able to do in real environments (p. 143). Participants described having high self-efficacy, being reflective practitioners and being willing to be self-directed learners as important for community-based work (p. 145 – 146). The importance of support, opportunities for networking, feeling that they were still part of the profession, as well as pay more commensurate with their hospital-based colleagues were mentioned as issues. Finally, community-based fieldwork experiences undertaken as students were described by study participants as having been helpful in their moves into community-based practice.

Thinking about *real* places, I think about Cutchin's (2004) challenge to occupational therapists to consider if what occupational therapists might be doing is helping clients with place integration. How do people adapt to new places, or to old places in which something (themselves, their family, friends, the physical arrangement of the environment) has changed or has to change? Cutchin suggests that, taking a Deweyan perspective, occupational therapists looking at the transaction between people and places might focus on continuity of person-place as a whole; what is contingent and what is emerging; intentions, plans and action; social, moral and aesthetic foundations; and place attachment and identity (p. 308).

As I look across the beads I have chosen to highlight the stories Katherine told of her experiences of *real* and *simulated* assessment, therapeutic activities and environments, I think about her struggles with institutional stories that promoted the use of high-tech evaluation systems over clinician expertise. I think about what Townsend (1996) found about how quickly occupation disappears (p. 123) in institutional settings, replaced by simulation. It seems to me that Katherine found ways to fight this, to do what Townsend suggests, which was to highlight the value of real occupation, both in places where that was somewhat easy and in places it was more difficult. I notice her willingness to move on when she couldn't effect change or wasn't willing to keep on struggling with work she found took her away from what she considered important. I think about how often Katherine might have been creating co-occupation with clients. I look at Katherine's use of occupational language, of her willingness to do more research about work simulation so she could say, with some conviction "Not close. Useful, but not close." I examine Katherine's stories in the context of Ramsey's (2011) study of community-based practice, and notice Katherine's confidence in being able to do what she needed and wanted to do, her self-directness, her ability to reflect on practice and her involvement in the professional community. I think about whether what she discovered early on wasn't the importance of place integration to her clients, and to her practice with them.

Looking at the beads I have stitched to highlight Dawn's stories of *real* and *simulated* occupation, my eye is drawn to the impact of her early

professional experiences in western Europe. Perhaps, like Ramsey's community-based therapists, those early experiences with working in environments that were designed to at least somewhat acknowledge residents' backgrounds and stories, the priority that the facility put on what could be labeled as place integration (Cutchin, 2004) helped give Dawn the experience of holism that she had committed to. Cutchin (2004, p. 310) describes place integration as happening when "change in the person–place whole occurs and place (the situation) becomes problematic, the challenge is to reintegrate person and place through activity". Having a real practice kitchen, being able to go out into the city to shop, residents having some of their own furnishings, familiar foods and daily activities, provided opportunities for place integration in this new setting. Dawn continued to reach for this lived experience when she started practicing in Canada. I notice, too, the ways in which she has reached for real in her assessment practices, and how she is now experiencing a bumping up between her personal practical knowledge of assessment and institutionally mandated assessment practices.

Looking at Alegría's stories of the 93 year-old lady, I think how well Alegría understood the importance of place integration when working with this memorable client. Looking at her story of stacking cones, and another early story of making baskets with clients, it seems to me she has struggled with real, and understood the power of doing together (Price, 2003, Price and Miner, 2007; Ward, Mitchell and Price, 2007). I think about Alegría's

willingness to struggle, and to be seen to struggle, as she moved from *embedding* occupation to *living* occupation and how she was consciously being a role model. Looking at what she has done as a manager, I note that she has, as Townsend (1996) suggested, changed how occupation therapy is described and organized. I consider how in her role as a manager she offers support and networking opportunities that the therapists in Ramsey's (2011) study identified as important for practicing in the community, in the real worlds of clients. I think about how excited the student I met who had done a fieldwork placement in the region was about seeing 'real occupation.' I note Alegría's enthusiasm for the COPM, and her realization that before staff could start using this tool they needed to start using the language of occupation, understanding how to stay with clients' stories.

Finally, I think about Margaret's stories of not having space for much of the real in her early work, either because she was a locum staff who didn't feel she could challenge existing programming, because she was working in a hospital or community setting where she didn't see people in their worlds, or because of role conflict with another professional. I think about the challenges of contested professional spaces, and how those can sometimes keep occupational therapists from doing what they see as real occupation. I think about Townsend's institutional ethnography and wonder how much space, time, treatment approach, and funding narrowed Margaret's choices, and created a bumping up place between stories from her early outdoor experiences and what she could do in those practice landscapes. I look at the

bead I've stitched next to her story of meeting real basic needs, and can see her smile and hear her excitement as she talked about how her practice was so *real*. Was what she did in that job largely supporting place integration into housing situations that provided new opportunities for clients?

○○Interwoven personal and professional identities○○

As I look across the coils that represent the stories I heard about *doing occupation* during this narrative inquiry process, I wonder about personal/professional identity. I remember Margaret's comment: "By no means could you dissect OT out of me". I think about Katherine as she composes a further life (Bateson, 2011), one in which she is no longer able to name herself as an occupational therapist because of regulations dictating use of professional title in the place where she lives. I think about the struggle that is, after all these years of living occupation. I look at what metaphorical beads I might gather to stitch along the coils, to mark stories that speak to me of OT identities. I think about mirrors and windows. I consider clear quartz and the mirrored black gleam of hematite, and think about how researchers work with, and through; how their own knowings influence what we see. I decide to choose both quartz and hematite beads to mark these stories.

Picking up a quartz bead and a hematite bead, I stitch them alongside Dawn's story of the Therapist Oath she took upon graduating from her occupational therapy programme in western Europe. Looking through the

quartz bead, I see that oath, magnified, and think just how much that oath has continued to guide her practice and shape the decisions she makes about being holistic, client-centred, and an advocate. I think about the occupational therapy oath I developed with faculty and students in one of the places where I've taught, and wonder if that oath has had the same impact on any of the students who took it. I listen again to Dawn commenting about what goes with or against the grain of her schooling, about what she misses from a healthcare system in her country that she sees as more holistic than the one in which she now works. Picking up two more beads, I stitch them side-by-side next to Dawn's stories of the theoretical foundations and models that were emphasized in her occupational therapy programme; one model perhaps given more weight through the association of the theory with a professor that she admired. Looking at the hematite bead, I think about the profound impact that reading and listening to that same theorist had on my career.

I choose two more beads, one clear, one mirrored, to mark Katherine's story of resisting a story from her occupational therapy programme about the need to be "nice presentable young ladies." I think about her leading the charge to be allowed to wear slacks to class, while around her the rest of the campus swirled with student protests. I turn from this story to Dawn's and consider what therapists' oath Katherine felt she was being asked to live, and how hard she worked to resist that story. Looking at the hematite bead, I think about my own first day of class, of being told by a professor, "It's a

waste of time training you girls, you'll all just get married, have babies and leave the profession." I consider how that bumped up against my stories to live by, how I resisted and was insubordinate. I think how much Katherine's stories to live by from childhood bumped up against the conservative nature of her programme. I wonder how Katherine and I might have spurred each other on, had we been in the same classroom. Picking up two more beads, I think about Katherine's current transition into retirement, and how difficult losing the right to call herself an occupational therapist has been. In the tutoring work she does now she uses occupational therapy skills and knowledge, but she comments that she must not call it occupational therapy. Looking through the quartz bead I notice how large is this loss of one of the names of who she is. Looking at the hematite bead, I think about my own four-year long sabbatical from occupational therapy, the new identity as an artist that I composed during this time, and how much I missed being able to call myself an occupational therapist in public. Stitching two more beads onto Katherine's stories of her work as an occupational therapist, I mark her commitment to being active in local, provincial and national occupational therapy professional association work. I think about the value both she and I give to this.

I pick up two beads to mark Alegría's story of choosing to be an occupational therapist rather than a physical therapist, after having been "combined trained". I stitch a clear bead to mark her story about the differences she sees between the two professions. I think about her telling

me that, when she made the change to working as an occupational therapist after having worked for one year after graduation as a physical therapist:

[A] With my PT buddies, it was as if I had leprosy.

I stitch a hematite bead to mark my own thoughts about occupational therapy as a rehabilitation discipline, and how well Friedland (1998) expressed my unease about how professions can be classified without understanding both fundamental and subtle differences between them. I think about how important effective inter-disciplinary education is in bringing differences and similarities into view.

Two more beads mark Alegría's stories of how she supports students, staff occupational therapists and occupational therapy assistants in understanding the unique contributions they could make through living occupation. I notice how the quartz bead enlarges what is underneath it, and I think about Alegría's commitment to getting bigger and bigger and bigger, and learning and learning and learning. I think about how she is sharing their stories of living occupation with a global community using technology. As I stitch the hematite bead, I think about my work with students in places where there is no occupational therapist on site, and the many, many discussions I've had over the years about "What would an OT do in this situation? What are you thinking of doing in this situation?" Looking at/in this bead, I am excited about the stories being told around the world by occupational therapists as a result of the Occupational Therapy 24-Hour

Virtual Exchange (OT24Vx), an annual online conference for which I am an organizer.

I pick up more beads, as I think about Margaret's stories. The first set, clear and mirrored, I stitch to mark her stories of thinking, but not being able to say as a student, her practice encompassed recreation and of moments of disputing professional turf with other professionals that I heard in her stories of early practice. As I look through the quartz bead, I think about how often play/recreation becomes lost in occupational therapy, with only time and mandate to look at very basic needs. I look at the hematite bead and think about my own turf wars over the years. I stitch another set of beads as I think about Margaret's passion for outdoor pursuits. Looking through the quartz bead, I note in doing so that each of the inquiry participants counts outdoor recreation, play, as important to their own health and happiness. I re-view the wonder I have about how we bring our stories to live by, our passions, our strengths in occupation (Hale, 2000), into our work as occupational therapists. Looking at the hematite bead I have stitched alongside Margaret's outdoor stories, I consider how infrequently I went into the outdoors with clients. I think too about how I've incorporated my passion for art and craft into work that clearly draws on my knowledge and skills as an occupational therapist, but do not label as occupational therapy.

Turning to the literature, I consider studies that have looked at occupational therapist identity, on entering professional education and in practice. An English study (Adams, Hean, Sturgis, Macleod Clark, 2006) of a

variety of healthcare profession students in the south of England found that first year occupational therapy students were second only to physical therapy students in already having a strong sense of professional identification. The authors review the research that describes how students gain professional identity even before they start their education. They suggest that procedures and rules that individuals encounter 'trigger" the building of professional identity (p. 57); and that role models who are professionals, clinical faculty, family members and mentors, all influence early professional identity development. Davis (2006) explored the importance of communities of practice in influencing students to move either towards, or away from, stronger professional identity. Ikiugo and Rosso (2003) reviewed the impact of a course that focused on the history of the profession, along with the social, political, economic and philosophical contexts that affect occupational therapy practice. Their findings suggest that there may be some benefit to focusing on these topics within professional education in terms of students' perceptions of gaining a stronger professional identity. Hooper's (2008) very interesting study explored how faculty biography influences instructional choices. As Hooper (p. 228) says, "educators in this study taught who they were". Hooper suggests that the influence of educator identity on the "implicit curriculum" (p. 228), and thus on student identity formation, is something that requires further exploration.

Wilding and Whiteford's (2007) participatory action research with a group of therapists working in an acute care setting showed that therapists'

professional identities and confidence increased when they changed the language with which they described and communicated their practice – from 'functional' to 'occupational.' Nicholson's (2012) study on becoming an "occupation specialist" found many of the same things as did Wilding and Whiteford's (2007) research – the importance of understanding occupational therapy's history and context, of language, and of creating spaces for communities of practice to explore occupation-based practice. Hanson (2009) notes, amongst other things, the importance of experience as well as opportunities for reflection, to becoming more occupation-focused. The value of supportive leaders, access to evidence and better inter-disciplinary communication is also described (p. iv). Estes and Pierce (2012) studied American pediatric therapists' perceptions of occupation-based practice. This study, using grounded theory, found that therapists' *doing occupation* was influenced by their professional identity and by their education. They describe these as the foundations for practice, along with the ability to creatively adapt to opportunities and constraints within the environments in which they practice. Holland, Middleton and Uys (2012) explore the idea of professional confidence, which they describe as including "an understanding of and belief in the role, scope of practice, and significance of the profession" (p. 214). They suggest that professional confidence and professional competence are associated, and are both relevant to professional identity. Paterson, Higgs and Wilcox (2005) report that identity is critical to having and using "professional practice judgment artistry." Participants in their

international study identified flow, conscious use of self, interactivity, and preserving self-integrity as some of the key elements of occupational therapy identity (p. 413). One further article from the occupational therapy literature may be relevant to the wonders explored in this inquiry. Mackey (2006), taking a Foucauldian stance, calls on occupational therapists to unearth and explore their identities, and to see the possibilities in being able to take on new identities within changing health and social care systems. Finally, ethicist Nelson (1995, 2001) explores identity and suggests that individuals within chosen communities can create spaces for development of counter-stories that can stand against the dominant stories within settings in which people work, and that individuals can effect narrative repair of damaged identity within these communities.

Turning back from the literature to the beads that mark Dawn, Katherine, Alegría and Margaret's stories of experience, I notice first that Dawn's stories of becoming an occupational therapist identify a strong mentor in one of her professors, and the occupational therapist during her Canadian fieldwork experience who always 'went beyond her duty.' I notice as I consider the literature and look at the beads with which I've marked Dawn's stories, the importance of a community of practice, and how Dawn misses being part of that here. I think about the ideas of professional confidence and professional competence and their joint contribution to professional identity, and see how Dawn has both competence and confidence in her chosen area of specialization.

Looking at Katherine's stories, I notice her strong belief in the role, scope of practice, and significance of occupational therapy, as shown in her ability to move into new practice areas while still maintaining her occupational therapist identity. Katherine, like Dawn, has been an active member within OT communities of practice and has done that throughout her career, mostly through professional association work, and through a special interest group. The importance of access to evidence is also apparent in Katherine's stories of being the first OT to graduate from the master's programme at her local university. As I think about professional practice judgment artistry as it relates to Katherine's identity, I notice her conscious use of self, interactivity, and self-integrity.

As I think about Alegría's experiences as a manager, I am struck by how she is a role model to others, and how much her admired colleague is a role model to her. I notice how, as a supportive leader, she creates spaces, and a community of practice, in order to help staff explore practice. I note how much she focuses on the use of language, and of using that language not only with other occupational therapists, but with other professionals and with clients. I notice her professional confidence. I also note her commitment to accessing and using evidence in practice.

As I look across the basket to the beads I've stitched alongside Margaret's stories, I note the value she places on interactivity, and conscious use of self. I think about Hooper's (2008a, p. 238) comment that "we teach

what we are" and think about what Margaret has learned about being an ally and how that now informs her work.

Finally, I look at Mackey's (2006) discussion, and acknowledging the benefits that multiple identities may offer in some situations, I also note the challenges this creates for practice. I further worry about how lack of a strong identity may create the conditions for occupational therapists to become gap-fillers (Fortune, 2000), and question whether this benefits anyone, even though there is a push for generic working to address workforce concerns within healthcare systems.

○○○Romantic ideals; Spiritual practices ○○○

Before stitching the next set of beads, I stop to contemplate how to characterize the next stories I want to mark. I think about the myriad ways occupational therapists talk about the heart, mind, and particularly the soul, of practice (Wood, 2004). I notice the conceptual murkiness that surrounds these discussions, and realize that I am journeying in the swampy lowlands (Schön, 1983, p. 42; Schön, 2001). I think about the ongoing discussion of underground practice, and think about how these stories I am marking might be considered underground practice that therapists then tell cover stories (Clandinin and Connelly, 1995) about. I consider Hocking's (2007, p. 36) discussion of the longing that occupational therapists carry for practice *as it should be* and wonder about the romantic ideals we carry as part of our professional DNA. I think about how much interest there has been recently in

understanding how Deweyan pragmatism plays out in occupational therapy, and note Dewey's interest in aesthetics. I think about how much I heard from the therapists who participated in this inquiry about matters of heart and soul. Considering all these things, I wade into the swamp where all the "problems of greatest human concern" (Schön, 1983, p. 42) lie. I acknowledge that, as I travel, I am attempting to shine some light on a complex inter-twining of related ideas, to open up a space for many new wonders.

I pick some particularly beautiful beads, shimmering with flashes of opalescent colour, full of intricate details that can only be seen up close, as I turn to look again at Katherine's stories of her client making a cup of coffee, and the woman who could no longer make exquisite birdhouses. I pick the most beautiful of these beads and stitch it alongside Katherine's story of asking her client to make coffee. I pause again to experience the emotions I have as I remember that story, and the emotion I've seen and heard in Katherine as she shares that story. I think about how other occupational therapists I've shared this story with have responded, often with teary eyes or expressions of gratitude for having heard the story. I think about a favourite line from St. Exupéry's (1943) *Le Petit Prince*:

> On ne voit bien qu'avec le cœur. L'essentiel est invisible pour les yeux.
>
> [One cannot see well except with the heart. That which is essential is invisible to the eyes]

I wonder again about how Katherine was able to see what was essential, to see with her heart, to use the occupation of making coffee to touch the heart

and mind of her client. I think again about sacred stories and the sacred story of occupational therapy, and wonder whether it lies glimmering in a space bounded both by the Romantic ideals that Hocking (2007) has identified as part of the occupational therapy's heritage, and the pragmatic ideas of Dewey that are increasingly being explored within occupational therapy/science. I stitch another shimmering bead next to Katherine's stories of the birdhouse maker and think about her description of her work as a spiritual practice, her 'ministry' to be able to get to know well enough to tell another's story. I remember Katherine talking about her reports as being like a painting or a sculpture. I think about how surprised I was to find the spiritual within a practice area in which I had arrogantly perceived it would be missing.

I pick a bead to mark Alegría's story about the importance of hope, to her friend undergoing chemotherapy, to her clients, to herself. I think about how she helps students and staff to be able to come forward as purveyors of hope. I remember her comment about how what we believe, how we support ourselves, enables us to get to certain places. I stich another bead to focus attention on Alegría's admired colleague, who works with such joy, who inspires Alegría daily, because she is willing to step forward, to notice the possibilities and not the barriers, whose beliefs help her get to certain places. I think again about the phrase *hopeful action* that Deans (1999) describes as the possibilities that arise from the twining of romanticism and pragmatism. Are Alegría, her admired colleague, and the therapists Alegría supports, living out stories of taking hopeful action?

I pick another bead to mark the story that Margaret tells of the moment in which she realized she wasn't Santa Claus. This story, which she tells with such emotion, and marks herself as a very significant turning point in her way of looking at helping versus being an ally, seems, at its heart to also be a spiritual story, of a change in seeing who she was in the world in relation to the clients she worked with. It is a story that marks the start of a transformation, a transcending of her previous views.

I stitch a bead to mark Margaret's stories of mountain treks. In these treks she designed experiences that introduced her fellow hikers to new challenges in the mountain landscape. That Margaret sees the reality, the grittiness and the glory of wilderness travel, allowing new possibilities in how participants saw themselves, seems again to reflect the Romantic ideas that Hocking identified, of the importance of the natural world, of transcendence, the importance of extreme situations and the value of emotional expression. As I stitch this bead I think about how occupational therapists find ways to make room for our clients' and our own spirituality in our work.

I take one final chatoyant bead to stitch next to Dawn's story of her long-ago classmate. I think about her empathy for him, her willingness to stand alongside him, so he wouldn't have to stand alone. I remember her telling me that she invited him to her birthday parties. I think about her moral sensitivity and courage.

What do I see in these luminous beads? As I look at them, and the stories they mark, I think about spirituality in practice. I think about empathy, about being able to cross over to another's world, return, and understand well enough both intellectually and emotionally. I think about morality. I think about standing up for, and with, others.

Turning to the literature, I note the ongoing discussion about spirituality in practice, and particularly the way in which spirituality has been incorporated into the Canadian Model of Occupational Performance and Engagement (Townsend and Polatajko, 2007). I realize with a jolt that I've always looked at this model, which places spirituality at the core of the person, as being a representation of, and reminder to attend to, clients' spirituality, but haven't looked at the person represented in the model with that spiritual core as also representing therapists. I look at Jung et al.'s (2008) idea of a set of telescoping lens through which occupational therapists can view clients, and notice that the lens labeled spirituality closely follows the first lens, occupation. I think about the importance of reflexively turning these lens on ourselves.

I re-read Belcham's (2004) findings about both the importance that occupational therapists place on spirituality, and the challenges they have in addressing it in their practices. Smith (2008), too, speaks of these struggles. Smith and Suto (2012) describe the decision-making clients with mental health concerns engage in as they choose religious/spiritual practices, and encourage occupational therapists to use therapeutic skills to enable clients

in making life-enhancing decisions about religious/spiritual beliefs and practices.

Turning again, I wonder about empathy as an expression of spirituality. I re-examine the words of Peloquin (1995) who, more eloquently than anyone else I've read, calls on occupational therapists to understand the richness of empathy that is available when we can not only *be* with someone, but also *do* with them; "bringing the trappings of occupation: objects, tools and activities" (p. 29). Peloquin (2005) asks us to think of empathy not just as something that enhances occupational and physical therapists' communication skills and helping relationships, but also as a "moral disposition for practice" (p. 11) that empowers therapists to act as moral agents in depersonalized healthcare settings. Davis (2005), in discussing educating for moral action, differentiates between moral sensitivity and moral judgement, and the ability to use moral courage to act. I think about the ten "enablement skills" that Townsend and Polatajko (2007) identify as critical for occupational therapists in effectively supporting clients to do what they need or want to do. In that list I notice *advocating*, *collaborating* and *engaging* as three ways of being that seem most likely to involve moral action. Taylor's (2008) exploration of therapeutic modes likewise encourages the conscious use of *advocating, collaborating, encouraging* by occupational therapists in addition to *empathizing* and other modes.

Exploring the links between nature, occupational therapy, and spirituality in thinking about Margaret's mountain treks, I find Servais

(2011) notes that most of the limited literature there is about this explores adventure therapy with 'at-risk' youth or clients with mental health concerns. She cites Levack's (2003) article that suggests that occupational therapy and adventure therapy meet through their emphasis on spirituality.

Finally, I read Paterson, Higgs and Wilcox's (2005, p. 414) description of a model of professional practice judgment artistry for occupational therapy that includes elements such as attunement, passion, grace and finesse, wise practice and heightened self-awareness. As I read this, I think about how much this model seems to me to represent many of the spiritual aspects of experience that I have marked with beads.

Turning back from the literature to the beads that mark Katherine, Alegría, Margaret and Dawn's stories, I notice how frequently and powerfully spirituality, empathy, and moral courage appear in these stories, although not always named as such. Katherine consciously evoked spirituality with the client who she asked to make coffee, carefully thinking about how to avoid negative *religious* connotations that she was aware of from knowing the client's early landscapes. In her medical-legal practice, she reflected on her own stories to live by, of being kind and understanding, and lived these stories, naming what she did as a spiritual practice, as a "ministry". Her willingness to travel to the parallel universes of her clients so she could understand shows her ability to empathize, to *world* travel (Lugones, 1987). Throughout her career, she showed moral courage, questioning the status quo as a student, clinician and manager; advocating for better access to

services, to alternative ways of offering services. In her medical-legal practice, she sometimes found that she was unable to provide the information that lawyers who had asked for her expert opinion were hoping for.

Alegría's stories about hope both reflect her use of a model of practice, the Canadian Model of Occupational Performance and Engagement (CMOP-E)(Townsend and Polatajko, 2007) that highlights the spiritual core of individuals, as well as her willingness to journey alongside clients. I think about the moral courage and sensitivity it takes to live occupation in settings where that remains a challenge.

Margaret's stories of learning to become an ally speak to an increasing moral sensitivity, moral judgment, and the ability to take moral action as she started to understand her own privilege. In that process, perhaps she began to use different enabling skills, and different modes than she had in the past. Margaret's earth-based spirituality and her expertise in outdoor skills, meant she had opportunities to enable others to be in nature, to have the potential for transformation that she had experienced through challenging herself and being in these natural places.

Finally, I look at the bead I have stitched to represent Dawn's willingness to take moral action, to stand alongside her childhood schoolmate, to continue to find ways to help her clients have experiences that allow them to start to build towards an imagined future. I think about her finding ways to incorporate physical activity in the work she does with

clients, and her own excitement about the skateboarder dude and what being on the hill with his friends, his past experiences, and his desire had afforded him the opportunity to do.

○○○○Staying or Going; Resisting or Relocating○○○○

I pick up several similar beads and stitch them along the coils that represent Dawn's stories of practice. As I do so I think about how Dawn has worked as an occupational therapist in three different places in two countries – in an extended care facility in western Europe and in Canada, in acute care and rehabilitation settings. In both places in Canada, Dawn has experienced considerable frustration in trying to live up to the ideals of the Therapists' Oath she took when she graduated: to be client-centred, holistic, and advocate for her clients. She has found it quite difficult to use *occupations as means*, or even to focus on *occupations as ends*, particularly in acute care. The continuing strength of the dominant story of biomedicine has influenced her opportunities to practice within the occupational paradigm that she first heard about as a student (Kielhofner, 1992). And yet, she has continued to strive to practice in ways that she sees as congruent with her childhood stories to live by, and stories she learned within the professional practice landscape of her education and early working. She has continued to persevere in practicing in a healthcare system that she sees as being more concerned with efficiency than with doing the best by their clients. She does

this with creativity and by going that extra mile to make sure her clients have the opportunity to do more than simply become more independent in basic activities of daily living.

I choose several more beads that are the same size and shape as the ones I've just stitched into Dawn's coils, but in a contrasting colour. I think about Katherine's stories. I stitch these beads onto the coils of Katherine's stories to bring attention to her choices. She learned during early student experiences that, without knowing about the parallel universes in which her clients lived, she wasn't likely to be able to have the understanding and empathy she needed to feel she could help her clients. She came to see that without knowing her clients' environments, she could not know much about their occupations. Having learned that, Katherine found staying within institutional settings was increasingly difficult for her. She held on to her understandings of what occupational therapy practice should be, and was willing to try out new places in which to practice, even if that might mean that other occupational therapists did not think she was still being an occupational therapist. She had a familial story to live by to sustain her as she travelled outside the hospital environment, of successfully pulling up stakes and going somewhere new, of doing something completely different.

I pick up beads of a similar shape and size, and of yet another colour as I mark Alegría's stories. I think about how she helps staff she manages to wait for the client, to stay with clients' stories, to persevere, to resist dominant

stories, and to build new stories of occupational therapy practice in the region.

As I think about these stories of staying or going, I think again about the research about occupational therapists' job satisfaction/dissatisfaction and reasons therapists may leave the field. I think too about the literature that discusses therapist resiliency, and the possibilities for resistance and insubordination. As mentioned in Chapter One, there are studies from several countries that explore occupational therapists' job satisfaction and/or attrition within the occupational therapy workforce. Lack of respect/recognition from other healthcare providers (Tryssenar, 1999; Moore, Cruikshank and Haas, 2006) is one issue identified in the literature. Workplace press for generic working is another (Hayes, Bull, Hargreaves and Shakespeare, 2006; Reeves and Mann, 2004). Slater and Brandt (2009) found high levels of moral distress in American occupational therapists related mostly to external factors such as limitations in funding, institutional policies and productivity standards that conflicted with what therapists through they *should* be doing for their clients. In an American study, Edwards and Dirette (2010) found high levels of burnout in therapists who reported struggling with professional identity and recognition. Conversely, therapists who felt the unique contributions that occupational therapy could offer were appreciated by their clients, and by third-party payers, had lower levels of burnout. Gupta, Paterson, Lysaught and Von Zweck (2012) studied occupational therapists in a Canadian province and found that workload,

conflicts arising from discrepancies between personal values and institutional mandates, lack of healthcare resources, lack of respect from others and lack of autonomy in customizing therapy were challenges for their respondents. Gupta et al. (2012) also identify coping strategies used by their respondents: spending time with family, friends and supportive colleagues, maintaining a balance between professional and personal life, preserving a sense of control over work tasks, keeping a sense of humour, and continuing to be self-aware/self-monitoring (p. 93). Aiken, Fourt, Cheng and Polatajko (2011) identified the *meaning gap* therapists experienced between practice as they thought it should be, and as it was. Strategies to address this meaning gap included: sharing and reflecting on clinical stories, using occupational language, co-creating meaning with clients, advocating within the team environment and making the meanings of occupation more visible (p. 301). Wood (2004) calls on occupational therapists to resist the possible *heartsickness* of practice through staying connected to the larger scholarly discussions within the profession, and being in community with colleagues. Molineux (2010) suggests the need for occupational therapists to gain greater *ontological security* in being able to articulate what they think are the shared foundations of the profession. Hooper (2006) calls on occupational therapy educators to explore new ways of knowing that will enhance our ability to be self-authoring as professionals. Nelson (1995, 2001) suggests that healthcare professionals may be able to resist dominant stories of

biomedicine through sharing narratives in a chosen community of colleagues as a means of developing counter-stories.

When I look at Dawn's stories of staying and finding ways to resist the pressures that take her away from practicing according to her therapists' oath, I wonder how she has been able to do this. She talks about being part of a very active professional community in her early practice in western Europe, how important that was to her, and how she misses that in Canada. Yet she has found ways to be in community with other occupational therapists here through teaching, supervising students, advanced training in an occupation-based assessment approach and now, in her graduate studies. I think about these graduate studies and the opportunities they can provide for exploring new ways of knowing. I see her trying to balance work and play, and have enjoyed her sense of humour during the research team's meetings. Dawn is well grounded in the theoretical foundations of the profession, something that began in her occupational therapy education. She is definitely someone who reflects on her practice and is able to articulate what she does as an occupational therapist and why she does what she does. I see, in her practice stories, that she works at co-creating meaning with her clients, so that they know why they are doing what they are doing in therapy and what this *doing* in the clinical setting might mean for doing in their own worlds.

Like Dawn, Katherine has been able to resist practicing in ways she felt were not true to her professional values as an occupational therapist. When the pressures were oppressive, or when she saw opportunities to practice in

new places where she felt she would be freer to use her personal practical knowledge as an occupational therapist, she was willing to make some rather large leaps, into the community, into peoples' homes, into private business, and into the courtroom. Katherine has been very active within the occupational therapy community throughout her career (at national, provincial and local levels), editing a column in a national professional publication, working on numerous committees to develop practice guidelines, as well as teaching and supervising students. Throughout her career she has looked for opportunities to further her theoretical understandings of the profession. She uses the language of occupation in describing her practice and is articulate in advocating for the value of occupation-based occupational therapy to others. Her practice stories show her co-creating meaning with her clients. She was the first occupational therapist to complete a graduate degree in occupational therapy from her local university, and has continued to actively engage in professional development activities. She is also someone who actively reflects on her practice. She worked hard at having balance between work, home and play, and made decisions about her work that gave her greater control over how she worked.

As I look between the literature and Alegría's stories, I am taken by how much she uses the literature as a way of exploring what other occupational therapists are struggling with, and succeeding in, with their practice. The work she has been doing as a manager very much parallels the work done by

Wilding and Whiteford (2007, 208). She has been actively engaged in addressing the *meaning gap* that Aiken et al. (2011) identified in practice. I note that she shares what she has read with staff so they know they aren't the only ones on the journey.

I look at Dawn, Katherine, and Alegría's stories of staying or going, and think about the power of early landscapes in shaping what we live, tell, re-live and re-tell in our professional lives. Who we are is in the living. When we bump up against stories that create tensions, that bumping may, but not always does, open up a space for us to examine those early stories, the stories we find ourselves in now in our practice, and the stories we want to live out in the future. Occupational therapists, like our clients, may find both loss and new opportunities for growth in these opened spaces. In these opened spaces lie opportunities for developing counter-stories that can stand in opposition to the dominant stories around us. Dawn's living of her therapist oath sometimes bumps up against a healthcare system that is not particularly open to her desire to work in a holistic, client-centred, and occupation-based way. Her advocating for her clients may sometimes fall on deaf ears. Yet she has found ways to keep living her oath within the system. Katherine, too, experienced many bumping up places, particularly as she worked within institutional settings. In the opened spaces she created, and pursued, new opportunities to practice in ways that let her live her early stories and create counter-stories that she shared with others (colleagues in private practice, students, people she worked with in professional associations) who sought

new ways of practicing. Looking at Nelson's ideas of chosen communities, and how work done in these communities offers narrative repair and encourages development of counter-stories, I think about the bumping up places Alegría has encountered as she has tried to shift practice to being more occupation-focused. I wonder if this bumping up may have created the energy for the workshops Alegría and her colleague designed.

Additional opened up spaces: Personal, practical, and social implications of this inquiry

The final tasks that remain in this dissertation are to return to issues that form of the base of this inquiry and to suggest how I can share what I have learned in undertaking this inquiry. At the base of this basket lie the personal, practical, and social justifications I outlined at the beginning of this inquiry journey. Now, as I make the last few stitches on the basket, I return to these questions and consider what spaces for seeing, and for further discussion, this inquiry may have opened. I will look at this from three perspectives – personal, practical and social, seeking to provide some, undoubtedly still in process, responses to the questions of "so what?" and "now what?"

Personal implications

What are the personal implications of having undertaken this inquiry? From a personal perspective, I consider that this inquiry has completed some narrative repair of my own identities as an occupational therapist, and

occupational therapy educator. While, like Dawn, I have always tried to live my understandings and beliefs about occupational therapy practice, I have been away from everyday clinical practice for enough time that I did not know well enough what was happening in the worlds of hospital and clinic and client homes. I had read enough of the literature that Alegría describes which itemizes the challenges therapists were having in working occupationally. I had heard stories from students returning from fieldwork about very technically-driven, non-occupation based therapy. While I had also heard stories of occupation-based, client-centred practice, these stories were considerably less frequent. My own experiences with my father's hospital and hospice stays as I was commencing this inquiry provided me with a sense that occupation-based practice was rare. I was starting to wonder if what I was teaching students was so far removed from what was happening in practice that I was setting them up for failure.

To have the exceptional opportunity to sit with occupational therapists within a chosen community and share practice stories, the ways we had, or were, continuing to *live occupation*, has given me renewed optimism. It has also, I hope, helped me become a better 'world' traveller and someone who is less likely to approach other occupational therapists with arrogant perception. There is an acknowledged divide between occupational therapists working clinically and those working in academia (Baptiste, 2011). As someone who will be continuing to work in academia, but in another country with a different healthcare system, it will be important that I

continue to live the lessons learned through this inquiry. One further personal lesson is important to acknowledge. As an occupational therapist, I have watched the development of the discipline of occupational science with both interest and some reservations, wondering if this would create yet another gap. Because of this concern, I have consciously set out to read in both the occupational therapy and occupational science literature as I framed, designed, and undertook this inquiry. I have come to see how important occupational science is to me as an occupational therapy educator, and to see how the work of many occupational scientists is undertaken with practice in mind.

As I consider the personal implications of this inquiry, I am also aware that the other participants have been affected at a personal level by being part of this undertaking. It is my hope that this has been an educative experience, and one that has given participants a chance for some narrative repair themselves as they shared their experiences. Responses from the participants as and after we collaborated on the narrative accounts suggest that this has been an educative experience for some or all, and happily, not a mis-educative experience for anyone. Two participants told me that they shared their narrative accounts with family and close friends. Katherine commented on how important it was to her to be part of this inquiry, as she begins composing a further life (Bateson, 2011) in retirement. In some ways, we came together as a small community of practice to explore wonders that we all have had in our work. I am interested in how/if these experiences will

influence participants in the future, and what hopeful action might come from this work.

Practical implications

What are possible practical implications of this inquiry? How might what I have explored in this inquiry shape occupational therapy education, and occupational therapy clinical practice? From an educational perspective, I suggest that the ongoing curricular focus on occupation-based practice, and a renewed interest in helping students reflect on, and use themselves, in therapy is something participants in this inquiry have confirmed influences their practice long after they leave the classroom. Helping students reflect on practice, and encouraging them to pursue not only technical skills, but also practical wisdom (Kinsella and Pitman, 2012), can help students as they move into practice.

The importance of having the skills, and the disposition, to listen to and deeply attend to clients' stories, and to their priorities and preferences, is also clearly articulated in the narratives explored in this inquiry. This is something that can be fostered within the classroom and in clinical fieldwork. Alegría and Margaret, in particular, comment that occupational therapy educational programmes and fieldwork preceptors share that responsibility. In the classroom, this could be fostered through instructors modeling active listening; through role-playing; through assignments that ask students to work with people who have lived experience of illness and disability who can provide students with feedback about how they are

perceived as listeners; and through reflection on movies, novels and blogs that present personal experiences. Taylor (2008) provides educators and students with some useful guidance in developing and refining these skills. I think the increased interest in learning from the narratives of persons with disabilities in the classroom parallels what each participant has achieved in their practice, even if it was not something they experienced in their own academic education. Supporting students as they start these conversations could help them become more comfortable with, and convinced of the value of, taking time to get to know clients well enough.

Education that explores how activities might become meaningful occupations through *doing with*, through co-occupation between client and therapist, is another discussion that might happen in classroom, lab and fieldwork places, and might shift practice towards being more occupationally-based. Consciously examining with students how shared intentionality, physicality and emotionality can be fostered in therapy could impact how they will work with clients. Pierce's (2003) discussion about increasing occupation's therapeutic power through attending to appeal, intactness and goal fit, seems related to these discussions of designing occupational therapy interventions that become co-occupations. Providing students with design opportunities where they consider appeal, intactness and goals fit might also be important. It is clear that the participants in this inquiry attempted to do this, even if they did not use those specific terms in telling practice stories.

Reid's (2009) idea of "presence moments" in occupational therapy might also be something explicitly discussed when educators talk with students about the art of practice. Discussions about mindfulness in healthcare practice are increasingly common, as is an interest in these practices within the larger community. An occupational therapy programme that integrated mindfulness into the curriculum might have some valuable opportunities for inter-disciplinary learning that would arise from examining mindfulness in practice across settings and professions. An understanding of mindfulness practices could potentially both enhance therapist-client communication, and increase occupational therapy students' understanding of what clients are doing in their everyday lives to be more mindful. Learning and using mindfulness practices has also been described as one possible way of enhancing clinician health and resilience (Ruff and MacKenzie, 2009; Shapiro, Astin, Bishop and Cordova, 2005).

The ethical challenges of practice, and the need to be able to advocate for clients, that participants have described also suggests to me that "educating for moral action" (Purtilo, Jensen and Royeen, 2005) is important. I wonder how space can be created for these discussions within the curriculum, and consider the possible contribution that health ethicists could make within occupational therapy programmes as well as in the practice places where students learn. Student awareness of healthcare systems and healthcare policies, as well as an awareness of larger social, political and

economic drivers could also influence their ability to recognize situations where moral action is critical.

I notice how each of the participants has a strong grounding in theory, and how that grounding helps them in practice. As an educator, I know that theory, and exploration of the historical and philosophical roots of the profession can be a *hard sell* for some students initially more interested in learning technical skills, but the experiences shared in this narrative inquiry show the value of this knowledge in sustaining therapists in their practice. Thus it is important to continue to not only introduce theory, but to weave discussions of theory throughout the curriculum, both in the classroom and in fieldwork settings.

Thinking again about Schell's comment about therapists using whatever is available within the environment in which they work and some of the stories shared in this inquiry, I am reminded of the occupation-based kits that Rogers (2007) and her students developed in collaboration with clinicians in fieldwork sites. I notice that University of Utah (2007) sends students into fieldwork with a list of ideas for occupation-based kits, as does, or has, Creighton University (2009, p. 10). I wonder how academic programmes and clinical sites could collaborate in research about the impact of having these additional therapy resources available, by means of student research projects that many academic programmes require their students to undertake.

The degree to which each of these participants is also a self-directed learner suggests another practical implication for professional education. I suggest that occupational therapy education programmes need to continue to help students become informed consumers of current research, understand the importance of continuing education, and partner with the clinical community in a two-way exchange of knowledge that goes beyond sending students out into the community to do fieldwork and inviting clinicians in as lecturers. Crist and Kielhofner (2005) suggest ways in which these partnerships between academic programmes and practice places could be enhanced. Merrolee Penman's doctoral research into occupational therapists as self-directed learners (personal communication, March 17, 2013) will also undoubtedly provide some insight into how or if occupational therapy academic programmes contribute to practitioners' ongoing education.

Implications for clinical work

There are a number of practical implications for clinical work that also arise from this inquiry. The importance of therapists having time to work in chosen communities to explore the language of practice, the historical and philosophical roots of the profession and to identify and develop strategies to deal with barriers to occupation-based practice, seems critical. As noted before in Chapter Seven when discussing identities, this inquiry is not alone in suggesting that these are important (Nicolson, 2012: Wilding and Whiteford, 2007). Development of structures that provide some of the same

functions as the occupational therapy departments of previous eras may be important in seeing that this occurs. This might fall under the purview of professional practice leaders within institutions, where such positions exist. It may come through efforts by professional associations, and, as noted above, through ongoing collaboration between academics and clinicians in teaching, learning and research. Support for clinicians working in home care and in other settings that do not have the same built-in educational opportunities that exist in hospitals, schools and rehabilitation settings is important. Access to technology that allows the meeting of minds across towns and across the globe is also likely to become an even more common way of helping practicing therapists continue to share their experiences, and has been identified by one participant as having been very important to her practice as a manager. For instance, online conferences like OT24Vx may become even more important in the future in supporting practice.

Social implications

As I consider the possible social benefits of this inquiry, I think about contributions to the occupational therapy profession and to society. I wonder about the potential impact of this particular form of inquiry, with its ontological commitments to the experiences of individuals and groups, and to a relational approach to research, for occupational therapy researchers. I propose that, because of occupational therapy and narrative inquiry's shared roots in pragmatism, and their parallel focus on hopeful action, narrative inquiry methodology, as developed by Clandinin, Connelly and associates,

provides a powerful way for occupational therapy researchers to explore the many wonders that remain within the swampy lowlands of practice. I would offer that narrative inquiry may also provide some possibilities for occupational science researchers, particularly in relation to an increasing interest in Dewey's transactionalism within occupational science (Cutchin and Dickie, 2013). I have become interested in thinking about place integration and occupational therapy practice while inquiring into stories of *doing occupation*. While my understanding of this concept is still provisional, it seems to me that place integration could be a possible starting point for future scholarly work in occupational therapy/science using a narrative inquiry approach.

It has been interesting to see in a recent publication on transactionalism and occupation (Rudman, in Cutchin and Dickie, 2013) that there is an interest in exploring the intersections between critical theory and pragmatism. Perhaps this exploration will provide a way forward for those interested in an narrative inquiry approach which travels somewhat more in the borderlands between narrative inquiry and critical theory than this inquiry did. In Clandinin and Rosiek's (2007) words, there is some exploration underway in the borderlands that lie between the philosophies that inform narrative inquiry and those which underpin critical theory. Clandinin and Rosiek (2007, p. 51) comment that ongoing attention to the impact of ideologies and social/political conditions "serve as a much-needed tonic for Pollyannaish liberal social policy that seeks an improvement to all

social problems through programs of individual self-improvement." They acknowledge (p. 64) that the narrative inquirer travelling in the borderlands with critical theory and other neo-marxist approaches will experience considerable tension, and must steer a course that does not ignore political and social conditions, and also does not minimize the contribution of learning from narratives of lived experience. It may, therefore be important for occupational therapy/occupational science scholars interested in narrative inquiry to further explore the borderlands between narrative inquiry and critical theory, and to engage with the ideas presented by critical theorists, while attending to the ontological commitments that they hold as narrative inquirers.

I note one further intersection that I hope this inquiry may provoke discussion about – that between Romantic ideals and pragmatism. I have come to wonder if occupation-based, client-centred practice might be positioned within this intersection, and would welcome further discussion and exploration of this intersection. Deans' (1999) phrase *towards hopeful action* as he looked at this intersection, has resonated with me, and with some of the participants in this inquiry. I wonder if scholarly work using a "history of ideas" approach might provide additional consideration of how these two philosophies intertwine, and how/if they affect occupational therapy.

If this inquiry can amplify the voices of other researchers who have, or now are, examining the complex set of wonders which cluster around

occupation-based practice, it is likely to help practitioners and practice leaders who wish to become more occupation-based to see possibilities for hopeful action in further attending to the external dynamics that Cooper (2012) talks about. As we start to have more evidence about the value of occupation to health, having a profession that is able to both talk and *live* occupation can provide benefits to society.

Sharing this narrative inquiry: A provisional plan

I have two tasks that arise from this inquiry. First, how could the ideas about occupation-based practice that came from this study be shared with clinicians, educators and students, and other researchers? Second, given the varied understandings of narrative inquiry within occupational therapy/occupational science (OT/OS) and that there appear to be no published research articles within these fields using narrative inquiry methodology as described and demonstrated by Clandinin, Connelly and their associates and as used within this inquiry, how could I add to the discussion of narrative inquiry in OT/OS? This may be a particularly useful time for this discussion, given the recent paper Bonsall (2012) published as part of his doctoral studies, that seeks to develop a typology of the varied uses of narrative in OT/OS. His typology describes narrative inquiry as purely a strategy used for analyzing narrative data, which is not how Clandinin and associates portray narrative inquiry. Further, an upcoming edited book by Molineux (in press) about occupational narratives may

provide yet another perspective on narrative inquiry methodology that is dissimilar to that used in this inquiry. The following brief discussion addresses my provisional plans for sharing the findings of this inquiry, and for furthering the discussion of narrative inquiry methodology in OT/OS.

Sharing this inquiry with students, educators and clinicians

Mindful of Greenhalgh and Wieringa's (2011) discussion of alternatives to the metaphor of *knowledge translation*, I propose a variety of strategies to share this inquiry with students and educators, and with clinicians, that might allow for further development of practical knowledge (*praxis*) and wise practice (*phronesis*). For instance, in addition to the usual strategies of writing several papers that communicate and further explore aspects of this inquiry, if the inquiry participants are willing, I would like to develop a workbook for students and clinicians that would use the narratives they shared as a launching point for discussions about the challenges and rewards of occupation-based practice. I envision this being used both in the classroom and in "chosen communities" of occupational therapists interested in exploring their practice. I further envision the possibility of a series of workshops that might use arts-based activities as a means of inquiring into therapists' experiences of occupation-based practice. I am also planning a collaborative presentation at a national or international conference with Nicholson, who has just completed a study of occupational-based practice with occupational therapists in New Zealand. This presentation will potentially address clinicians and educators, as well as researchers, and may

provide an interesting means of looking across two studies that both focused on occupation-based practice, using two distinct research methodologies.

Sharing this inquiry with OT/OS researchers

My plan for contributing to the discussion of narrative inquiry methodology is to submit an article which comments on Bonsall's (2012) suggestion that narrative inquiry is merely an analytic strategy for analyzing narrative data. I will, of course, submit articles for publication that discuss both the methodology and the findings of this inquiry. My proposed poster presentation on narrative inquiry methodology has been accepted at an upcoming national conference. I anticipate that a paper might arise from this poster, which will examine the shared pragmatic roots of narrative inquiry and occupational therapy and suggest that this methodology has much to offer OT/OS researchers. Finally, I plan to attend and present at conferences at which the focus is narrative/narrative inquiry to show how narrative inquiry methodology was used in exploring practice within a specific healthcare profession.

Stopping before one more turn

In this chapter, I have turned from looking at individual narrative accounts to looking across the participants' accounts. Looking across the coils of this narrative inquiry basket, I have noticed both where stories lie tightly against each other, where they bump up against each other, and the spaces that this bumping up creates. I have chosen four wonders related to

doing occupation that I have discussed further: reaching for the real, identities, complex issues related to the heart, mind and soul of occupational therapy (Wood, 2004), and participants' strategies for resisting or escaping systemic pressures to practice in ways which are not compatible with their personal practical knowledge.

I have attempted to address the personal, practical and social implications of this inquiry, and to suggest how this research will change my practice as an educator, how it might inform occupational therapy education more generally, and perhaps how it contribute to further scholarly work in occupational therapy/occupational science through providing an example of a methodology that can be useful. I have also suggested how this inquiry might be a starting point for further discussions about the twined philosophical roots that might inform occupational therapy practice and allow for further hopeful action.

As I complete this dissertation, I have one remaining task, even while acknowledging that inquiries arise in the midst and continue on, long after the final word of this document is written. This task is to share, within the Epilogue, my B*asket-maker's Studio Journal* with the reader. This journal, which includes some of my field texts, provides some small windows into the inquiry journey and the inquirer, using both words and images. It starts by describing a particular form of basket-making, and then moves onward to provide some sense of the wonders, joys and struggles that attended this venture. It is a collage of words and images similar to that which I keep in a

variety of journals in my studio – inspirations, ideas for future work, and reflections on my current projects.

Epilogue: The basket-makers studio journal

Image source: http://barbara-shapiro.com/gallery/baskets/
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Reflections of a basket-maker

> *The fine art of basket weaving became a metaphor for my life. Here were all these separate pieces that needed to be woven in such a way as to create something useful, even beautiful in its own way. The intricacies of patterns, the choice of materials – reed or oak or willow; dyed or not – and even the ultimate shape of the basket all went into the process of creating one. Even as I learned the proper method of weaving around the spokes, thus ensuring that the entire thing would not fall apart, I came to realize that I had to do something similar to my memories, weaving the past into the present to create a whole (and wholesome) life. A basket is meant to hold many things; it is up to the owner of the basket to decide what should go into it. The same was true for memories …* (The Findaráto Diaries, Fiondil, n.d.)

Encouraged by Sharoff's (2009) discussion of the value of metaphor in nursing practice and research, while acknowledging Thorne and Darbyshire's (2005) admonition about the over-use of metaphor in qualitative research, I start exploring a metaphor for this particular narrative inquiry process. This metaphor is not something with which I consciously came into the inquiry, but something that has gradually emerged through the process, and one which I initially resisted as being too "easy" and obvious given my professional and personal identities as an occupational therapist and artist. I might have also been resisting an image that, at early points in my career, stood, in a pejorative way, for my profession. I have been labeled a "basket-weaver", and, although that now is more a badge of honour than something to be ashamed of, perhaps I still carry some of the sting of that comment with me. One non-OT blogger describes how basket making has come to be such a negative symbol of occupational therapy: (http://whereapy.com/blog/therapy-blunder-basket-weaving). She suggests that in replacing the basket with "a highly regarded symbol**,** Occupational Therapy might come to be properly understood at a glance." The image called to me, and, although my participants laughed when I told them I was thinking about using a basket to represent the research process, I took it as a knowing laugh. This is part of my resistance and insubordination (Nelson, 1995).

I have come to see my inquiry process as being somewhat akin to weaving a coiled, beaded basket similar to the one shown above. To make a coiled basket like this, the artist begins with bundles of flexible grass or

needles, or cord – something that is either one apparently solid piece, or can be bundled together to create a core. Perhaps this core might consist of "an enormous multiplicity of strands of evidence, many of them weak and ambiguous, [which] can make a coherent logical bond whose strength is enormous" (Gauch, 2003, p. 93). I propose that occupation, co-occupation and occupation-based practice as experienced, defined and researched the profession of occupational therapy constitute part of the core for this basket. In this inquiry, the core also consists of my own education and practice experiences, those of my participants, as well as my understandings of the professional literature (philosophical and investigative) I have read and re-read about occupation, co-occupation and occupation-based practice.

The basket-weaver gathers these core materials and begins weaving by binding the ends of the core bundle with a thin strip of bark or a length of twine, wool or wire. This end is shaped and bound into a round or oval for the base. As the weaver works, she creates coils, held together by winding a weaving strand around the core for a length, and then connecting the coil she is working on with the one that preceded it. Coiled baskets can be stitched (technically they are not "woven") together so they are "close-coiled" (no space between coils) or "open coiled" (intricate knots or beads can be used to separate subsequent coils). Stitches may be "simple" (go around the bundle, then through the coil below), "intricate" (knots created between coils that separate them) or may "wrap" (going only around the bundle being worked on and not penetrating the coil below). Wrapping stitches may be used in

combination with intricate stitches. If the weaver closely spaces wrapped or simple stitches, the centre bundle may not be visible in her finished basket. The weaver also needs to consider the "best side' of the basket and then stitch from the outside – in or from the inside – out; the side on which the needle and thread enters is often the "best side", although it is possible with attention and skill to have both sides look good (source: Coil Basketry, Native American Basketry: http://www.nativetech.org/basketry/coilindex.html).

Which threads did the weaver use to wrap this bundle of occupation/co-occupation-based practice? Stories of experience. Participants' stories, my stories, sometimes a single strand, sometimes multiplied as we explored our practices together.

Narrative inquiry uses three commonplaces to explore experience – moving backward and forward, inside and out, and considering place. As this inquiry process took place, the weaver moved backward and forward along the length of the coiled bundle. She looked inward and outward, worrying about making the "best side" she could in representing her stories and the stories of her participants, revealing and sometimes hiding where a new thread joined or where something wasn't smooth; this even though she wanted something deeply and unevenly textured like the experiences she was focusing on. She thought about how to keep the bundle, occupation, visible, while knowing that because working occupationally is often "underground practice" and thus hidden by therapists, she would have to

create space along the wraps along the coil and between the coiled layers. As the basket took form, occupation and co-occupation appeared and disappeared. She, lover and maker of beads, thought about how beads could represent markers along the coils – highlighting participants/her stories of occupation-based practice that seemed most relevant to her inquiry either in showing how occupation was visible or was covered. She pictured these beads as places where her readers would stop and look closely at the stories being told, the bundle around which they were wrapped, the coils above and below, the inside and the outside. Perhaps the beads would create a space too for the reader to recall their own stories of practice.

She thought about the usefulness of the basket as she shaped it. She wanted it to be useful not only to herself, but to her participants and even, she hoped, to other occupational therapists. Knowing of the shared commitment to pragmatism of occupational therapy and narrative inquiry, she hoped to be able to answer the "so what?" "who cares?" and "now what?" queries of at least some of the people who had watched her slowly weaving the basket. Would its form be useful to someone else exploring some aspect of practice? Would its particular highlighting of specific aspects of occupation-based practice encourage others to reflect on their own practices? What possibilities for resistance and insubordination were woven into it? What could it contain or carry? Would it have a beauty that would speak to others?

She thought about all of these as she shaped and stitched her inquiry basket.

Research poems

Anxieties of a novice narrative inquirer

It's not like I was out dancing
In the rain
Wearing skimpy clothing
On the Corbett Hall lawn…

Dawn, Dissected

Dawn, dissected
Lifted stories, severed from
Her stories to live by
As I play the smarty game

Kind encouragement to go back
Unpack
Write
Seat in chair or pomodoros
Send me a story, every 3 days
I will read it

Breathing again
I take up my basket

On the need for unpacking

Running [on] ahead
I know what this story is about
Oh
I didn't unpack it and show you?
[or did I unpack it so slowly, repetitively, you felt insulted]

That was me hurrying
That was me jumping forward

Without looking backward, inward, outward
Thinking about place

That was me
Slapping a luggage tag on the handle
Leaping to conclusions

SLOW DOWN
Breathe
When you run [on] no one can see the story

Full hands

Narratives spiraling
Out of control
"There's such a bigness to it"

Reflections

On awaking from a dream

So activity becomes occupation through the artistry of both the therapist and the client. That speaks to Pearson's idea of appeal, intactness and goal fit. In this dream I had the most wonderful example of how therapists use aesthetic senses to bring appeal. The therapist used appeal to the senses of sight and taste. She set the table with the values of symmetry, harmonious colour, and other ways to keep appeal in mind. This was a dream that on the surface wasn't a therapy session but rather a party, or a gathering of friends, with the most amazing food and environment. But symbolically it was a therapy session and obviously points my thinking about what makes a therapy session great. I think that's another question I have to ask my participants – what are the ingredients of a great therapy session?

This obviously was also standing for my hope about what our research group meetings will be like.

I will have to look into Patterson, Higgs and Wilcox's (2005) writings on the artistry of practice. I don't know if it applies in this situation.

Has anyone ever talked about therapy sessions as analogous to hosting someone in your own home? This could be an interesting pursuit. We know that the research suggests that the most powerful therapeutic contribution to

the outcome of therapy is the relationship between the therapist and the client. Perhaps what happens with occupational therapy is that the relationship is built through the therapist attending to the client's personal occupational profile.

Price (2003) talks about therapeutic activities becoming occupation. I need to read again about how she believes this happens. I'm thinking it happens through the therapist engaging the client was something that has sufficient appeal, intactness and goal fit that what the therapist has started becomes the client's own activity and thus an occupation.

Reflections on writing a narrative account

I've been thinking about love, ethics of care, the stories we don't tell, how those untold stories shape the stories we do tell …

And somewhere in the midst of this cogitating, I thought again about the Johari Window. The idea of the Johari Window is that there are four panes in the window – one represents what we know about ourselves that is also known/visible to others; a second, aspects of ourselves that we don't see but are known to others; a third, things about us that are both unknown to ourselves and invisible to others; and fourth, that which we know but we keep from others.

I've been thinking about how what I know about myself, and what I do not know, what others see of me, and do not see, influences my inquiry. I've been thinking about what my participants know and show of themselves, influences my inquiry.

I've been struggling a bit with a narrative account that has some tender spots. In the relational work of this inquiry, I struggle because I know more than I can (should?) say. I struggle because I think I can see this individual's blind spot and I don't know how this person will respond to my gentle wondering about this. I struggle because I know I have blind spots too, and how do I lovingly inquire into this as I write. I think this is where response communities can be so helpful. To ask questions kindly that say, "I'm not sure what you mean here" or to share a story that bears the gift of saying "Me too" or "That's completely different for me, but perhaps it can help".

I'm looking at two beads I made this summer. These beads contain glass that has high silver content. Silver glass and some other colours of glass create interesting colours when they touch. In making these beads, I mostly didn't want the silver glass to touch the orange glass, but instead wanted the combination of orange and silver to make vibrant pink. So to make these fuchsia beads, I started with a core of orange glass, encased it with clear glass, then layered on the silver glass, reduced it (bathed it in a propane rich

flame), then turned the flame to neutral and encased the bead in another layer of clear glass. When I was successful in completing the process I have described, I had a pink bead. When orange glass was able to travel through the wraps of clear glass and was then in contact with the silver glass, there were streaks of blue and green. I think about these streaks of blue and green and the interaction between inquirers. I think about knowing, being known, telling, what happens when we don't tell. I think about love, and a colleague who said, not completely admiringly, "You think love can solve everything". I think about loving and arrogant perception, and hope that I can be loving, think about my truths, this person's truths, the stories we have lived together and what my intent is here.

Hands full of stories
My own stories bleeding through
Pentimento

As I start to write the final chapter

Looking along, inside/outside the coils you notice different things than when you look across all of the coils that make up the basket.

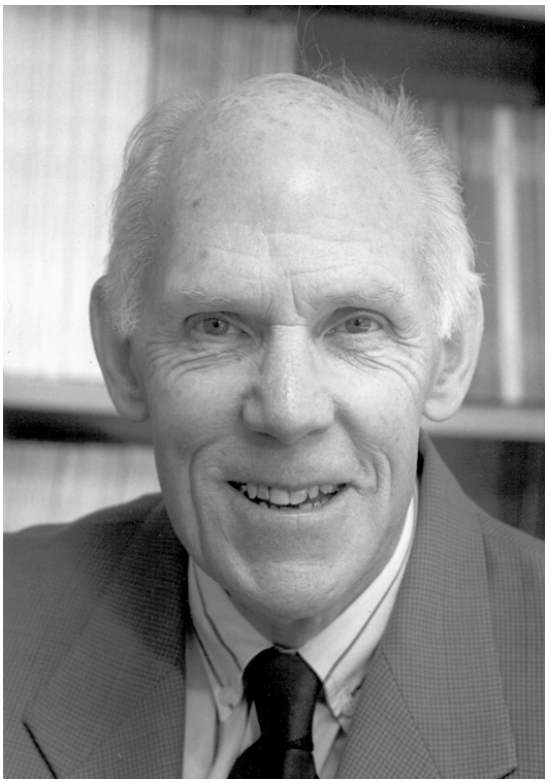
Communities of practice – how have they participated, created?
Education
Interrogate their practices
Are we here to judge, to help, the walk beside… loving perception, empathy vs. sympathy…

Hidden shapes I have woven/coiled around, my own stories, what I knew and could not tell, what I did not know, what remains mysterious, what I knew and participants knew – Johari windows intersecting.

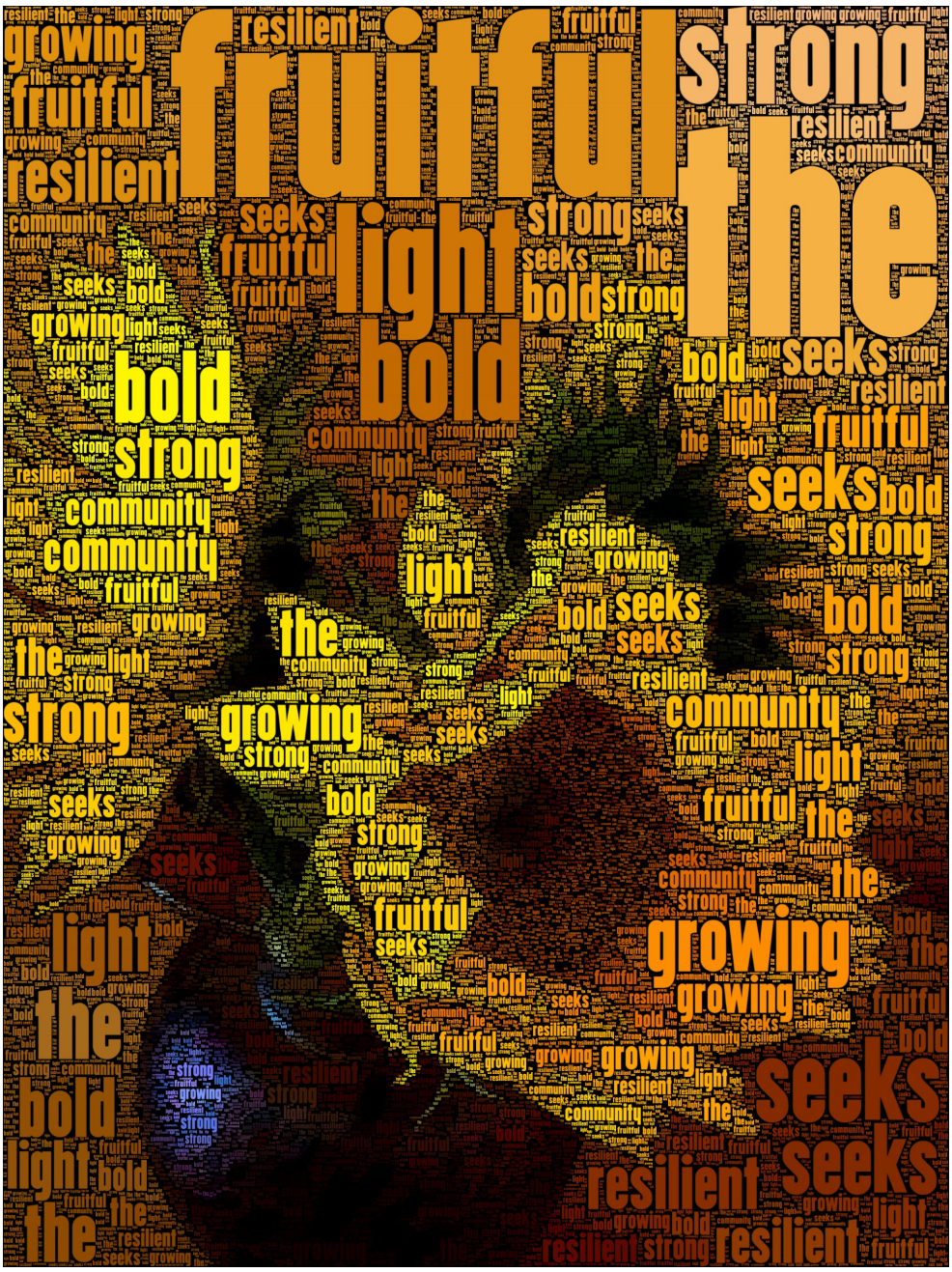
Unfinishedness – start in the midst, end in the midst, although for K is the ending of being formally named as an OT and the beginning of being a grandmother.

Up sleepless, like Dad
Basket seems so well stitched within each account, now the hard work of stitching, linking across while holding stories of experience as central – again to that ontological commitment.

Inspirations



Ronald A. Burwash 1925 – 2011
Quaecumque vera



Words, Photograph and image: S. Burwash, 2012

Curriculum Summary

Cheryl Mattingly:
These women [and men - SCB] with their weekend gardenia plantings [hmm- I've never planted a gardenia - SCB] were fierce in their determination to sweep the corners free of dying where they could. Patients would return to their jobs, their wives, their toilets and bathtubs, their woodworking and law practices, their golf and kitchen chores. They were missionaries of common sense and decent morals. Armed with these they marched into bad situations to see what could be done. My encounter with the occupational therapists plunged me into a world darker than any I had lived in, a world that seasoned therapists traversed easily, full of practical good ideas. The existential and the commonsensical travelled side by side. (Mattingly, 1998, p. 52)

Word image: S. Burwash, 2012

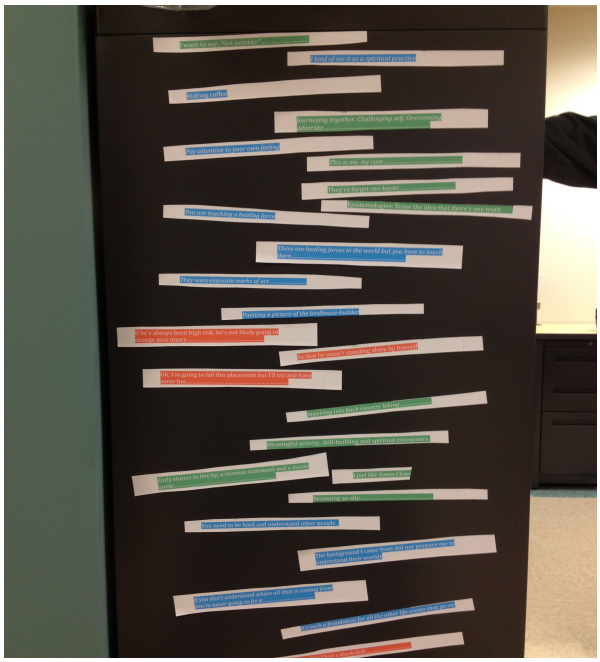
OT24Vx 2012

Fragments

Maybe great therapy moments become that through "making special"? Ritual, etc. Check out Dissanayake again. Co-creation, co-occupation …

Process Pictures

Image: S. Burwash, 2012
Great advice



Photograph: S. Burwash, 2012

Laying stories alongside each other

Words, Photograph and image: S. Burwash, 2012

10-word dissertation summary

Photograph: S. Burwash, 2012

Everything flows …

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