

**An exploration of the different forms of
theoretical knowledge valued and used by
occupational therapists in mental health practice**

Samantha Elizabeth Ashby M.App.Sci (Research), BSc (Hons), DipCOT

This thesis is submitted in fulfilment of the requirements for the Degree of
Doctor of Philosophy (Occupational Therapy) School of Health Sciences,
University of Newcastle, NSW, 2308, Australia

April 2013

Statement of Originality

The thesis contains no material which has been accepted for the award of any other degree or diploma in any university or other tertiary institution and, to the best of my knowledge and belief, contains no material previously published or written by another person, except where due reference has been made in the text. I give consent to the final version of my thesis being made available worldwide when deposited in the University's Digital Repository, subject to the provisions of the Copyright Act 1968.

Signed: _____ Samantha E. Ashby

Date: _____

Presentations and Publications Arising From the Thesis

Refereed Journal Publications:

Ashby, SE, Ryan, S, Gray, M & James, CL 2012, 'Factors that influence the professional resilience of occupational therapists in mental health practice', *Australian Occupational Therapy Journal*.

Conference Paper Presentations:

Ashby, SE 2010a, 'Professional journeys in mental health: Developing professional resilience', in *15th World Federation of Occupational Therapy Congress*, Santiago, Chile.

Ashby, SE 2010b, 'The theoretical knowledge valued and used by experienced occupational therapists working in mental health practice', *15th World Federation of Occupational Therapy Congress*.

Ashby, SE 2011a, 'Exploring how occupational therapists use theoretical knowledge in mental health practice ', *COT Annual Conference*.

Ashby, SE 2011b, 'Exploring the theoretical knowledge used in mental health practice ', *COT Annual Conference*.

Ashby, SE, Gray, M & Ryan, S 2012, 'Professional resilience for occupational therapists in psycho-social practice', in *Canadian Association of Occupational Therapy*, Quebec City.

Acknowledgements

I wish to acknowledge and thank all the occupational therapists who participated in this research, without whom this study would not have been possible.

I acknowledge the financial support provided by the University of Newcastle with an Early Career Researcher Grant and an Equity Fellowship Grant which made this study possible.

Thank you to my colleagues within the School of Health Sciences at the University of Newcastle, for your support and encouragement.

A special thank you goes to my Supervisors Professor Susan Ryan, Dr Carole James and Dr Kylie Agllias, for their support and scholarly advice. I would also like to acknowledge Professor Mel Gray who acted as my Supervisor from 2007-2011, and who has provided direction throughout this journey. Thanks also to Pamela Trevithick for her discussions on practice knowledge during her visits to Australia.

My biggest source of support has been from my family and friends. Without the continuous support and generosity of Simon, Katherine and Nicole I would not have been able to complete this thesis. I would also like to acknowledge the encouragement and support I received from my parents, aunts and uncles in my educational journey.

CONTENTS

An exploration of the different forms of theoretical knowledge valued and used by occupational therapists in mental health practice.....	ii
Statement of Originality	ii
Presentations and Publications Arising From the Thesis.....	iii
Refereed Journal Publications:.....	iii
Conference Paper Presentations:.....	iii
Acknowledgements.....	iv
Table of Tables	8
Table of Figures.....	9
GLOSSARY	10
Definition of Knowledge Domains	17
Abbreviations.....	18
Abstract.....	20
CHAPTER 1: INTRODUCING THE STUDY	22
Background to the Study	23
Study Purpose and Research Plan	26
Research Aims and Questions	27
Overview of the Research Design.....	28
Significance	29
Structure of the Thesis.....	30
Conclusion.....	33
CHAPTER 2: PERSPECTIVES ON PROFESSIONAL PRACTICE KNOWLEDGE	35
Defining Practice Knowledge in Health and Social Care	36
Historical Perspectives on Practice Knowledge: An Evolving Praxis	41

Sociocultural Perspectives: Contextually-Shaped Knowledge	44
Structural Perspectives: Power Relationships in Practice	47
Perspectives of Knowledge Use in Health and Social Care	48
Classifying Theoretical Knowledge	50
Grand Theories or Meta Models	51
Discipline-Based Theories: Occupation-Focused Models	51
Using Occupation-Focused Models in Occupational Therapy Practice	56
Frames of Reference in Occupational Therapy Practice	59
The Tacit Dimension of Theoretical Knowledge Use	60
Conclusion	63
CHAPTER 3: APPLYING THEORETICAL KNOWLEDGE IN OCCUPATIONAL THERAPY PRACTICE	65
Origins of Occupational Therapy	65
Törnebohm's Theory of Personal Paradigms	69
Theoretical Knowledge: Its Relationship to Changes in Professional Identity, and Language	74
Defining Formal Perspectives of Occupational Therapist's Knowledge and Professional Identity	76
Educational Discourses in Occupational Therapy	78
Impact of Educational Level on Appreciation and Use of Theory .	81
The Use of Theoretical Knowledge in Mental Health Occupational Therapy	83
Conclusion	88
CHAPTER 4: INFLUENCES ON OCCUPATIONAL THERAPY PRACTICE IN MENTAL HEALTH	90
Mental Health Policy in Australia: Influences on Occupational Therapy Practice in Mental Health	91
Occupational Therapy Mental Health Practice	94
Competing Discourses in Mental Health Practice	100

Tensions in Interprofessional Teamwork.....	104
Professional Isolation	105
Communication	106
Case Management and Generic Working	107
Perceived Lack of Respect	109
Conclusion.....	111
CHAPTER 5: METHODOLOGY	114
Purpose of the Study.....	114
Research Questions.....	115
Using Qualitative Methodology	116
Adopting an Interpretivist-Constructivist Research Approach	116
Narrative Inquiry.....	118
Reflexivity	119
Research Process	121
Stage 1: Literature Review	122
Stage 2: Ethical Issues Relating to The Study	122
Stage 3: Sample Selection and Recruitment	122
Demographics of The Participants.....	125
Stage 4: Data Collection	126
Research Diary	127
In-depth Interviews.....	129
Stage 5: Data Analysis.....	138
Step 1: Pre-reading	142
Step 2: First cycle coding – developing concept-driven codes	142
Step 3: Reading and cross-sectional coding of transcripts	143
Step 4: Second cycle coding-Analysis of themes	145
Step 5: Narrative thematic analysis	146
Step 6: Adding and coding new data	147
Step 7: Rewriting and cross-analysis of themes	147
Stage 6: Dissemination and Writing of Thesis.....	147

Trustworthiness of Findings: Application of Quality Assurance

Criteria 148

Credibility149

Transferability150

Dependability150

Confirmability and authenticity151

Limitations of the Study 151

Conclusion..... 152

CHAPTER 6: FINDINGS PART 1—DEVELOPING PERSONAL

PARADIGMS AND THEORETICAL KNOWLEDGE USE IN MENTAL

HEALTH PRACTICE 154

Section 1: Professional Journeys and the Value and Use of

Theoretical Knowledge..... 155

A Description of the Participants and Their Workplaces156

The Professional Histories: Commonalities.....157

Three Stories From Across the Spectrum of Personal Paradigms160

Diana’s story – Professional ambivalence..... 161

Bronwyn’s story—Purpose, contradiction and confrontation—A
dynamic shift..... 164

Alex’s story – Consolidating Professional Ideologies and Identity .. 170

Episodes in Professional Histories173

Pre-entry level stories: Influences on the value placed on
occupationally-oriented theoretical knowledge..... 173

Entry-level program: Valued theoretical knowledge..... 174

First jobs career stage: Professional identity and action..... 176

Ideal jobs: Finding the right match 179

Section 2: Developing a ‘Professional Toolbox’-The Integration of

Different Forms of Theoretical Knowledge in Participants’ Mental

Health Practice 182

Use of Professional Knowledge Domain186

Occupation-Focused Models Shape Professional Identity and Reasoning.....188

Tacit Use of Occupation-Focused Models190

Developing Professionally Bilingual Skills.....	193
University Curricula: Source of Occupation-Focused Knowledge and Models	195
Using Psychological Frames of Reference	196
Adding Psychological Frames of Reference to a ‘Professional Toolbox’	197
Losing the Balance: Adapting Psychological Frames of Reference Through an Occupational Perspective—Intentions vs. Realities	204
Combining Different Forms of Theoretical Knowledge in Tandem—‘It’s a Balance’	206
Combining Different Forms of Theoretical Knowledge in Tandem: Steps in Maintaining the Balance	208
Conclusion.....	212
CHAPTER 7: FINDINGS PART 2 —DEVELOPING PROFESSIONAL RESILIENCE AND THEORETICAL KNOWLEDGE USE	214
Dominant Discourse Dimensions in Mental Health Practice Contexts	215
Practice Knowledge Dimensions.....	218
Biomedical Practice Knowledge Discourse	218
Psychology Practice Knowledge Discourse.....	218
Dominant Discourse Dimensions: Living With The Tensions.....	220
Living with the Biomedical Discourse	220
Living with Recovery Approaches	224
Living with Psychology as a Dominant Discourse.....	225
Living with Evidence-Based Practice Discourses	225
Maintaining and Developing Professional Resilience: Strategies for Living with Tensions.....	228
Developing an Assertive Stance-Dealing with Competing Theoretical Discourses in Mental Health	229
Developing Negotiation Skills.....	231
Using Occupation-Focused Theoretical Knowledge and Professional Values as Protective Factors	233
Protecting Professional Identity: Knowing when it’s Time to Go.....	234
Seeking Support Networks: Sociocultural Dimensions and Communities of Practice	235
Professional Supervision	238
Conclusion.....	240

CHAPTER 8: DISCUSSION.....	241
Section 1: Dominant Discourse Dimensions and the Use and Value of Theoretical Knowledge.....	244
Discourse Dimensions in Mental Health Practice	244
Practice Knowledge Dimension	245
Living with the Tensions Created by Discourse Dimensions	249
Section 2: The Role of Professional Resilience in Supporting Valued Theoretical Knowledge and Occupation-Based Practice in Mental Health Workplaces.....	251
Being and Becoming Professionally Bilingual	257
Professional Socialisation	260
Formal and Informal Networks	261
Professional Supervision with an Occupational Therapist	262
Section 3: Developing Personal Paradigms – Using Occupation-Focused Models	263
Influence of University on Valuing and Using Occupation-Focused Models in Mental Health Practice.....	265
Transitioning into Practice: Influences on Using Occupation-Focused Models	267
Describing the Uses of Theoretical Knowledge	268
Using Occupation-Focused Models in Practice	269
Section 4: Applying Psychological Frames of Reference in Mental Health Practice	273
Influences on Valuing and Using Psychological Frames of Reference	274
Using Psychological Frames of Reference	277
Prioritisation of Psychological Issues	277
Section 5: Introducing a Unifying Professional Practice Typology for Understanding the Different Forms of Knowledge Domains Integrated into the Phronesis of Occupational Therapists	280
Conclusion.....	284
Gap Filling and Role Blurring.....	287
CHAPTER 9: CONCLUSION	289
Implications for Educators	292

Curricula Design.....	293
Implications for Employers of Occupational Therapists in the Mental Health Workforce.....	297
Supporting Professional Resilience at Macro and Mesolevels	298
Supervision.....	301
Implications for Occupational Therapy Mental Health Practitioners	303
Occupation-Focused Models	303
Psychological Frames of Reference.....	305
Recommendations for Research.....	307
Further Research into the Integration of Theoretical Knowledge in Curricula	307
Further Research into Professional Resilience	308
Further Research into the Use of Occupation-Focused Models in Mental Health Practice	309
Further Research into Use of Psychological Frames of Reference in Mental Health Practice	310
Limitations of the Study	311
Conclusion.....	313
REFERENCES.....	315
APPENDICES	340
Appendix I-Human Research Ethics Committees' Approvals.....	341
Appendix II-Information Statement	342
Appendix III-Consent Form.....	346
Appendix IV Interview Schedule.....	347

TABLE OF TABLES

Table Number and Title	Page Number
2.1: Forms of knowledge in professional occupational therapy practice	37
2.2: Various Classifications of Knowledge	40
2.3: Occupation-focused models	52
2.4: Levels of environment named in social ecological theory, with examples from mental health-adapted from Bronfenbrenner (1979)	55
3.1: Australian Bureau of Statistics' (ABS 1997) classification of occupational therapy	77
3.2: Summary of occupational therapy mental health research, which included theoretical knowledge use	85
3.3: Frequency of models used by mental health occupational therapist in Craik, Chacksfield and Richards' (1998) UK study	86
4.1: Australian occupational therapists mental health practice (Ceramidas 2010)	96
4.2: Summary of generic skills identified in three international studies of occupational therapy mental health practice	98
4.3: Summary of discipline-based skills identified in three international studies of occupational therapy mental health practice	99
5.1: Stages in the PhD research process	121
5.2: Description of participants' entry-level education	125
5.3: Participants' careers in mental health	126
5.4: Timeline for data collection	130
6.1: Participants' practice context	157
6.2: Common career stages in professional journeys	159
6.3: Participants' use of different forms of theoretical knowledge	185
6.4 Examples of knowledge from the professional knowledge domain	188
6.5: Use of occupation-focused knowledge in practice	189
7.1: Social ecological factors in the workplace	215
7.2: Themes and subthemes in the development of professional resilience	229
9.1 A Summary of major findings, research implications, and practice implications	291

TABLE OF FIGURES

Title of Figure	Page Number
2.1 An adaptation of Trevithick's (2012) unifying professional practice typology	38
2.2 An example of codified knowledge in occupational therapy (Ashby 2010)	54
5.1: Research design and methods used	127
5.2: Spectrum of valued and used theoretical knowledge	136
5.3: Iterative process	139
5.4: Stages involved in the coding of the data	140
6.1: Structure of professional history	158
6.2: Different forms of theoretical knowledge use, and implications in practice (Ashby 2011a)	186
6.3: Representation of the forms of knowledge domains used in practice by the participants	207
8.1: The socioecological model adapted to reflect how occupational therapists' mental health practice is influenced at different levels	242
8.2 Socioecological levels in mental health practice	247
8.3: The PRIOrity (Professional Resilience, Identity, Occupation) model, in which occupation-based practice is supported by, and impacts on, professional resilience	253
8.4 Unifying professional practice typology for understanding the different forms of knowledge domains integrated into the phronesis of occupational therapists	282

GLOSSARY

Key Terms	Definitions
Borrowed or shared theoretical knowledge	Occupational therapists in mental health practice adopt or borrow knowledge from other professions, primarily psychology (Duncan 2006). The forms of borrowed theoretical knowledge are often described as frames of reference.
Codified or propositional knowledge	Codified or propositional knowledge includes discipline-based theories and concepts, which are integrated with practical processes and procedural knowledge, and further influenced by subjective impressions, interpretations, and experiences to create practice knowledge (Eraut 2007).
Community of practice	Communities of practice are groups of people who share a concern or a passion for something they do and learn how to do it better as they interact regularly (Wenger, McDermott & Snyder 2002). In occupational therapy they can include the professional networks, organisations, and professional reference groups.
Conceptual knowledge	Conceptual knowledge is espoused theory, which guides practice but is not directly responsible for occupational therapists' treatment interventions. (Osmond 2005).
Explicit knowledge	The knowledge practitioners can articulate and link to practical actions

Frames of reference	<p>For consistency throughout the thesis I use the term ‘frame of reference’ (Krefting 1985; Townsend & Polatajko 2007) to refer to those theories containing propositions or rationales, which underpin treatment approaches. According to Duncan (2006) they are ‘theoretical or conceptual ideas developed outside the profession but with judicious use, are applicable within occupational therapy practice’ (p. 45). This term is used to refer to models of practice based on propositional knowledge: They have explicit assumptions, propositions, and provide treatment approaches. They provide a bridge between theory and practice and offer hypotheses and propositions for treatment interventions (practical actions and behaviour) (Blesedell Crepeau, Cohn & Schell 2009; Krefting 1985; Mosey 1981; Townsend & Polatajko 2007).</p> <p>The American Psychological Association (2012) describes psychological frames of reference as ‘theories of psychotherapy’. These psychological frames of reference include Acceptance and Commitment Therapy (ACT) (Hayes & Lillis 2012); Dialectical Behavioural Therapy (DBT) (Linehan et al. 1999); Narrative Therapy (Madigan 2010); Brief Solution-Focused Therapy (BSFT) (de Shazer 1988); Cognitive Behavioural Therapy (CBT) (Beck 1976) and Contemporary Attachment Theory (Schoore & Schoore 2008). In the occupational therapy literature additional frames</p>
----------------------------	---

	of reference described are the behavioural, humanistic, and psychodynamic (Duncan 2006).
Instrumental use of knowledge	Instrumental use – denotes directly observable changes in behaviour or practical actions (Dunn 1983 cited in Osmond 2005). In this thesis, it refers to knowledge used directly with service users to work on a specific impediment to their engagement in their chosen occupations, i.e., those things people do to maintain their self-care, engage in leisure or productivity, which can include paid or unpaid forms of work.
Mental health practice	A term used in the Australian public health system. It encompasses other terms referred to in the occupational therapy literature – ‘psychiatric’ and ‘psychosocial practice’.
Meta-models	Traditionally, the classification of theories depends on what they seek to explain. For example, grand theories, or meta models (Mills 1959), are overarching theories which attempt to explain more or less everything in society by drawing on abstract conceptualisations, such as scientific theories and research.
Midrange theories	Occupation-focused models are midrange theories as they seek to describe one phenomenon and do not provide direct interventions for practice.
Occupational therapy	Occupational therapy is defined by its international governing body, the World Federation of Occupational Therapists (2012) [WFOT], as:

	<p>A client-centred health profession concerned with promoting health and wellbeing 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 (p.4).</p>
Occupations	<p>In occupational therapy, a core aim of intervention is the enablement of meaningful occupations to promote health and a sense of wellbeing. In the language of this unique professional domain, occupation is defined as meaningful by the client and can include 'chunks of activity that can be named in the lexicon of the culture' in which the person lives (Zemke & Clark 1996, p.vii) .</p>
Occupation-based practice	<p>This is the explicit use of occupation to achieve a client's goal – a goal orientated to his or her occupational issues. It focuses on service-users' occupational issues and enhances and supports an occupational perspective. Occupation-based practice involves the use of occupation as both a 'means' and 'end' of therapy (McLaughlin Gray 1998).</p>

Occupation-focused models	<p>Midrange theories describe occupational behaviour and participation devised by occupational therapists for use in the profession. In occupational therapy, Duncan (2006) defines midrange theories as ‘occupation-focused theoretical constructs and propositions that have been developed specifically to explain the process and practice of occupational therapy’ (p. 45). Occupation-focused models are thought to be conceptual, and central to the study of occupation. They offer a theoretical basis for practice by providing explanations about the process and practice of the profession (Ashby & Chandler 2010; Duncan 2006).</p>
Paradigms	<p>‘Professional paradigm’ is a term which, when used in occupational therapy, is defined as a shared consensus about the most fundamental beliefs of the profession (Kielhofner 2009). ‘Personal paradigms’ (Törnebohm 1991) reflect a social-constructionist approach. They are unique to particular situations, and they are the result of collective context-based processes rather than universal movements. Törnebohm distinguished between a therapist’s personal paradigm, which comprises four mutually reinforcing components, namely, (i) worldview, (ii) interests, (iii) field of action, (iv) competence, and the broader professional paradigm.</p>
Personal knowledge	<p>Personal life experiences form part of the ‘personal knowledge domain’ (Bazeley 2007).</p>

Phronesis	‘Phronesis’ or ‘practical wisdom’ is the prudence and capability of a person to consider a mode of action and to deliver change in order to enhance their quality of life or personal wellbeing (Hughes 2001a).
Practice wisdom (personal knowledge)	A term used to describe craft knowledge, and the judgements required to make professional decisions. It refers to the Aristotelian notion of ‘poiesis’. It is the use of knowledge with judgment or with wisdom (Trevithick 2012).
Practice theory nexus	The intersection that occurs during clinical interactions with service users.
Praxis	The action resulting from professional judgements. According to Aristotle, disciplines can be divided into three categories: theoretical (theoria), technical (techne), or practical (praxis). These divisions are derived from his observations of how people in each discipline makes the decisions, which influence their practical actions, referring to this professional reasoning and decision making process as praxis (Hughes 2001a).
Process or procedural knowledge	This refers to the practical application of knowledge to occupational therapy process during assessment, treatment planning, and evaluation phases, i.e., ‘how to do things’.
Professional codified knowledge	An overarching term which includes discipline-based theories and concepts, which blend with practical, process and procedural knowledge, based on impressions, interpretations and

	experiences, to create practice knowledge (Eraut 1994).
Propositional knowledge	This refers to the factual knowledge generated formally through research and scholarship: 'It includes scientific knowledge (from the sciences), aesthetics (from the arts) and logic (from philosophy)' (Higgs, Jones & Titchen 2008, p. 154). It requires translation into procedural knowledge or the 'knowing how' used in practices.
Recovery	A terms defined by Anthony (1993, p. 11) as 'A deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and or roles. It is a way of living a satisfying, hopeful and contributing life. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of psychiatric disability'.
Service user	The term 'service user' is used in this dissertation as it reflects its use in Australian policy documents, and recovery approach literature. Other literature refers to service users as clients, patients or consumers.
Tacit knowledge	Tacit knowledge describes the intrinsic practice knowledge which forms a practitioner's thinking and doing which can be espoused through the use of reflective practice (Polyani 1966; Schön 1983).
Technical rational	The term technical rational skill is used to describe the skills and practices of professionals,

skills	or artisans. It indicates a focus on the technical aspects of practice and the instrumental knowledge that informs 'how to' (Schön 1983).
Theoria	Theoria refers to the knowing, or informing which underpins an action.
Theoretical knowledge	In occupational therapy, theoretical knowledge is usually described using the terms 'paradigm', 'conceptual models of practice' and 'frames of reference' (Duncan 2006).

Definition of Knowledge Domains

Professional knowledge domain	In this thesis, this term refers to occupational therapists' philosophical core beliefs and assumptions. These assumptions include occupational wellbeing – described as 'an experience in which people derive feelings of satisfaction and meaning from the ways in which they have orchestrated their occupational lives' (Townsend and Polatajko 2007, p.372). This also refers to the efficacy of occupation as a therapeutic medium.
Theoretical knowledge domain	In occupational therapy, theoretical knowledge is usually classified as conceptual or directional – guiding practice through treatment approaches and specific therapies. However, as noted in the thesis, little is known about how different forms of theoretical knowledge are integrated into occupational therapists' practice in mental health. Some authors in the health profession describe theoretical knowledge as 'propositional' because

	theories are based on propositions or assumptions (Higgs, Jones & Titchen 2008).
Service-user domain	<p>This domain refers to the expertise of service users regarding their lived experience of mental illness and illness experience.</p> <p>Service users can also refer to those people who care for, or live with a person with mental health issues, who are also involved in developing plans with the person and the occupational therapists.</p>
Personal knowledge domain	This refers to pre-profession and the personal experiences of work and life which impact on professional practice.
Factual knowledge domain	Factual knowledge refers to codified, or research-based knowledge. It contributes to the ‘knowing what’ aspects of practice. For occupational therapists in mental health practice, this includes knowledge from the clinical sciences, psychiatry, along with policy knowledge about State Mental Health Acts and other relevant legislation.

Abbreviations

ACT— Acceptance and Commitment Therapy

BSFT— Brief Solution-Focused Therapy

CBT—Cognitive Behavioural Therapy

CMOPE— Canadian Model of Occupational Performance and Engagement

CPD —Continuing Professional Development

DBT—Dialectical Behavioural Therapy

MOHO—Model of Human Occupation

OPM -Aus—Occupational Performance Model-Australia

ABSTRACT

This thesis adds new insights and understandings about the integration of theoretical knowledge in the personal paradigms of occupational therapists in mental health practice, a previously unexplored area of research. The qualitative research used narrative inquiry to explore the professional histories of nine occupational therapists who worked in mental health practice in a regional area of Australia. Thematic analysis of professional histories highlighted the crucial episodes, practice contexts and social values, which informed the value and use of different forms of theoretical knowledge across time. This study contributed new information about the nexus between occupation-focused models and practice by identifying a spectrum of theoretical knowledge use. Bronfenbrenner's (1979) social ecological model provided a lens to view the data and to consider the ways in which macro, meso and microlevels' environments shape practitioners valuing and use of different forms of theoretical knowledge. If used in tandem, the tacit use of occupation-focused models conceptualised and drove the direction of therapy towards occupational goals, whereas the explicit and instrumental use of psychological frames of reference resulted in visible explicitly psychologically oriented practical actions. Findings suggested professional self-care strategies, including professional socialization and the adoption of negotiation skills, were key responses to environmental tensions, which arose from the practice knowledge discourse, and dominant discourse dimensions. Pressures to adopt biomedical and psychological discourses often diminished the use of the occupational perspective discourse in phronesis and praxis and subsequently on reduction of occupation-based practice.

The study identified that drawing upon professional knowledge domains and occupation-focused models appeared to protect professional identities. Professional resilience and identity were crucial in assisting practitioners to resist the pressure to adopt, rather than adapt, psychological modalities. This thesis highlights the need for further research into strategies at the macro, meso and microlevels which maintain the use of occupation-focused theoretical knowledge and the development of professional resilience in mental health practice.

CHAPTER 1: INTRODUCING THE STUDY

The focus of this thesis is to explore the theoretical knowledge valued and used by occupational therapists in mental health practice. This qualitative research study focused on nine occupational therapists who worked in mental health practice in a regional area of New South Wales (NSW) Australia. It explored their professional histories and how their valuing and use of different forms of theoretical knowledge developed and was shaped by crucial episodes, practice contexts and social values throughout their professional careers. Where appropriate I have written this thesis in the first person to make my presence explicit, and make my stance and decision-making processes more transparent for the reader.

The focus of the thesis is on how practitioners synthesise different forms of theoretical knowledge occupation-focused models, and frames of reference, in practice. In the thesis, I have described the process by which practitioners gather, analyse, and synthesise different theories (explanations) to arrive at a tentative understanding, hypothesis or judgment about a service-user's occupational issues (Trevithick 2008a). Following the data collection, I employed a socioecological perspective adapted from Bronfenbrenner (1979). This enabled a broader perspective through which to better understand what shapes the development of practitioners' personal paradigms. Thus, the areas of influence explored in this thesis included the practice context, the team, the policies, management perspectives, and sources of theoretical knowledge.

In addition, I explored: (i) the ways socioecological influences affect the value and use of different forms of theoretical knowledge; (ii) how theoretical knowledge illuminates practitioners' understanding of a person's occupational issues, their roles and responsibilities in relation to those issues, and the practice approaches, perspectives, skills and

interventions recommended, or used, to address the problems presented; and (iii) how theoretical knowledge guides and directs practice and how it is integrated with other domains of knowledge to provide a wider understanding of people, situations, and events.

Background to the Study

The original impetus for this study came from my experiences as a clinician and educator in Australia and the UK. In identifying my research question, I drew on my personal experiences from 22 years of professional practice in a range of practice contexts. These have included experiences in education, mental health practice, occupational rehabilitation, and physical rehabilitation. Within practice contexts, I encountered people with differing occupational issues and was aware of how service delivery methods were affected by macro and micro institutional policy. In mental health, I experienced the issues of role blurring, the challenge of explaining occupational therapy to other health and social care professionals, and working in a joint role of occupational therapist and case manager. These issues are common experiences for occupational therapists (Harrison 2005a; Lloyd, King & McKenna 2004b; Whitcher & Tse 2004) who often feel their roles in multidisciplinary teams are poorly understood (Molyneux 2001; Skjørshammer 2002).

The choice to focus on theoretical knowledge came from my belief that, in health and social care, the use of theory to underpin occupational therapy practice is likely to be key in ensuring the continuance of clinical competence, and in the provision of rationales for occupational therapy interventions (Egan 2003). However, little analytical attention has been paid to how the professional knowledge valued and used by occupational therapists in mental health practice is shaped by their practice context and policy influences and if – or why – occupational therapists place a low

value on all forms of theoretical knowledge, as the literature suggests (O'Neal, Dickerson & Holbert 2007).

A practitioner's ability to describe and justify his or her occupation-based interventions to colleagues is becoming increasingly important in mental health practice (Fortune & Fitzgerald 2009). Similar to other areas of health and social care, occupational therapists in mental health practice are increasingly expected to articulate, and provide evidence for, their decisions and actions. The ability to account for, and justify treatment interventions and outcomes is vital in evidence-based health and social care settings (Cusick 2001). This requires practitioners to be aware of the diverse forms of knowledge underpinning practical actions including discipline-based theories and concepts which are integrated with practical, process, and procedural knowledge, impressions, observations, interpretations, and experiences to create practice knowledge (Eraut 2007).

In addition, knowledge of the theories underpinning occupational therapy practice allows practitioners to better articulate their role and rationales for interventions to others. As an educator, I have been aware of the potential for dissonance to occur between academics and practitioners often caused by abstract 'theoretical language' (Fargion 2007). To overcome this dissonance I developed workshops, which provided practitioners with explanations and translations of these terms (Ashby 2000; Ashby 2008; Ashby 2010b). These workshops demonstrated while the predominant discourse in occupational therapy claimed there was a dissonance between theory and practice, practitioners' reflections in these workshops refuted this. During these workshops, occupational therapists described a wider use of theory, to a greater extent than was reported in professional literature. The difficulty experienced was the need to reflect upon its use, and finding the words to describe its use to others (Ashby 2000; Ashby 2008). These workshop experiences, along with my teaching in undergraduate and postgraduate programs, led me to choose to explore the

use of different forms of theoretical knowledge which guide practical actions, and how chosen theoretical knowledge affects occupation-based practice.

I chose to contextualise the study in mental health practice because, along with my personal experiences of working in this setting, historically, international literature has described the challenges for occupational therapists who work in this area (Paul 1996; Renwick et al. 1990). These challenges are often related to professional identity and role. The challenges faced by Australian occupational therapists in mental health practice result in difficulties in the recruitment and retention of occupational therapists into the mental health workforce (Hayes et al. 2008; Scanlon et al. 2010).

Studies in occupational therapy, have investigated mental health practice in developed 'Western' contexts: Australia (Bartlow & Hartwig, 1989), Sweden (Haglund et al. 2000; Wikeby, Lundgren Pierre & Archenholtz 2006), and the United Kingdom (Craik, Chacksfield & Richards 1998; Harrison 2005b; Harrison 2005c; Wikeby, Lundgren Pierre & Archenholtz 2006). However, few studies have focused on the knowledge underpinning practice, and there is only one published study relating to the theoretical knowledge used by occupational therapists in Australian mental health practice (Bartlow & Hartwig 1989). This study found that, similar to Swedish practitioners, Australian mental health occupational therapists drew on a range of theoretical knowledge, and were most likely to use psychological frames of reference (Bartlow & Hartwig 1989; Haglund et al. 2000). Thus, in mental health practice a smorgasbord of conceptual and instrumental theoretical knowledge exists (Osmond 2006). As I sought to explore the interface between what forms of theoretical knowledge are valued and what is used, mental health practice seemed to be a source of rich information.

I have chosen to use the terms ‘conceptual’ and ‘instrumental’, put forward by Osmond (2006), as these terms delineate the different ways practitioners use theoretical knowledge. These terms emphasise the clinical utility of different forms of theoretical knowledge rather than trying to define it within a distinct category of knowledge.

I posited that occupational therapists’ choices of theoretical knowledge in mental health practice might be based upon practitioners being drawn towards those theories which reflect the dominance of other disciplines and the ways these theories interpret the underlying problems facing service users. In addition, I was also interested in the influences on an occupational therapist’s choice of theoretical knowledge, and whether this was affected by the tensions created by the competing, and more dominant biomedical and psychological discourses in mental health practice.

Study Purpose and Research Plan

The purpose of the study was to build on previous research, which has explored how occupational therapists employ different forms of theoretical knowledge to direct practical actions in interactions with service users. It also investigated what shapes the relationship between what is valued and used to direct practical actions. This area of research is significant as an argument exists in occupational therapy that, to provide authentic occupation-based therapy, or practical actions which enhance and support an occupational perspective, requires practitioners to draw on theories from their own field or paradigm (Haglund et al. 2000; Molineux 2011a).

My intention in this research study was to focus on the relationship between the value practitioners placed on specific theories, such as occupation-focused models and frames of reference. I also explored how they used or adapted frames of reference in their practice. I assumed this process of adaptation or translation of frames of reference might be the key to understanding how an occupational focus in practice might be lost, even

by those who valued occupation-based models and occupational therapy's professional philosophy.

Research Aims and Questions

The aim of this study was to explore how occupational therapy practitioners who work in mental health settings, in a regional area of NSW, Australia, combine different forms of theoretical knowledge in their professional reasoning and the consequences for occupation-based practice. The overall research questions I explored were:

1. How and why do occupational therapists value theoretical knowledge in mental health practice?
2. How do occupational therapists in mental health practice use occupation-focused models of practice?
3. How do occupational therapists use psychological frames of reference: derived from psychological theories?
4. How do the social environments, such as practice contexts and communities of practice, shape the different forms of theoretical knowledge valued and used in practice?
5. What is the nature of the relationship between a practitioner's use of different forms of theoretical knowledge, their personal paradigm and practical actions?
6. How does theoretical knowledge evolve and potentially inform the practical actions of experienced occupational therapy mental health practitioners?

Thus, the intention was: to better understand how theoretical knowledge forms part of practice knowledge; to identify what supports occupational therapists working in mental health to use valued theoretical knowledge in daily practice; and to recognise what influences may prevent them from doing so. These new understandings could then be used to inform the

mental health content of entry-level education curricula to meet the needs of occupational therapy graduates, and to ensure continuing professional education is practice-driven and relevant to practice contexts.

Overview of the Research Design

Methodologically, I chose a qualitative research design as it enabled me to capture the participants' experiences of practice and explore in-depth the range of issues which affect the theoretical knowledge they value and use in mental health practice. Narrative inquiry was chosen as the framework for the study because Polyani (1966) and Eraut (2000) argue storytelling and case studies are useful techniques for revealing professionals' tacit knowledge. Therefore, this design allowed an exploration of the ways in which practitioners blend different types of theoretical knowledge into their practice and how this is valued compared to other forms of knowledge. To contextualise the research into one jurisdiction, I conducted the research with occupational therapists who worked in a range of practice settings within Hunter New England Health Area Mental Health Services with people across the life span.

I gathered the data using two one-to-one in-depth interviews and member checking with each participant after each occasion. I chose these methods as they had been successful in eliciting practitioners' use of practice knowledge in other disciplines, including nursing and teaching (Eraut 2007; Holloway & Freshwater 2007). These methods allowed me to explore and gain a deeper understanding of practitioners' use of theoretical knowledge. An iterative process of data analysis and interpretation began immediately after the completion of the first interview and continued until the completion of the study. The process involved working back and forth between the data and the literature. I analysed the verified transcripts from each interview, along with my field notes and reflective diary, and coded

them using NVivo 9 (QSR), a computer-assisted qualitative data analysis package. I used the data to develop an analysis of the phenomenon under study, namely, practitioners' use of knowledge to guide practice (Holloway & Freshwater, 2007).

Significance

This is the first research directly exploring the relationship between the theoretical knowledge valued by occupational therapists, and what is used in mental health practice. The study contributes to the development of a greater understanding of the role which different forms of theoretical knowledge play in occupational therapists' phronesis and praxis in mental health practice. This is important, because as Kinsella and Whiteford (2009) noted, the use of theory is likely to determine occupational therapists' practical actions. Understanding what underpins practice is a key step in identifying what can improve, or act as barriers to, the paradigm-dependent occupation-based practice (Fortune 2000).

The exploration of the socioecological influences on practice broadens the debate away from an individual's practice to the consideration of the power relationships affecting practitioners in the mental health workforce (Foucault 1980). While power relationships have been considered within the occupational therapy literature (Griffin 2001), and in consideration of professional identity (Mackey 2007), no previous studies have explored how power relationships impact on theoretical knowledge use and practical actions in mental health practice (Kinsella & Whiteford 2009). Hence, the study considers how the practical actions of occupational therapists in mental health practice are influenced by ideas and therapies from other more dominant discourses. In these ways, the study extends the research into the interplay of the multiple factors which shape the relationship between a practitioner's values and use of theory, and the

Chapter 1: Introducing the Study

choice of one theory over another (Schell & Schell 2008). Through discovering what contributes to the theoretical knowledge valued by occupational therapists it may be possible to better support practitioners' use of occupation-based practice. Exploration of strategies, which maintain professional identity and job satisfaction, may also assist in countering the difficulties in recruitment and retention of the occupational therapy mental health workforce, as identified by Scanlon et al. (2010). It also provides empirical evidence for the planning of undergraduate and postgraduate curricula, and continuing professional development courses in occupational therapy education.

This research increases the potential to create research synergies across interdisciplinary groupings as the unique subject of the thesis has interdisciplinary links. An investigation of professional practice knowledge in mental health is of concern for practitioners in all health and social care disciplines working in mental health settings. The findings may also have relevance to the practice of family therapists and counselors in the human services.

Structure of the Thesis

The literature review spanned perspectives on practice knowledge, the use of theoretical knowledge in occupational therapy, and occupational therapy mental health practice in the context of Australian health and social cares settings. These three topics are presented in Chapters 2, 3, and 4.

Chapter 2, 'Perspectives on Professional Practice Knowledge', reviews the different perspectives and theoretical frameworks used to analyse and describe professional practice knowledge in the health and social professions. It discusses with the conceptual frameworks adopted to explore the relationship between practice knowledge and power relationships, considers what influences professional education, and

Chapter 1: Introducing the Study

explains how dominant discourses in mental health impact on the knowledge practitioners value and use in practice (Bernstein 2000; Delanty 2001; Foucault 1980). It includes a synopsis of the evolution of the philosophy of knowledge from Aristotle to the present. This chapter also analyses forms of theoretical knowledge with examples from occupational therapy.

Chapter 3, 'Applying Theoretical Knowledge in Occupational Therapy Practice', presents literature which reflects the historical and contemporary use of theoretical knowledge in occupational therapy practice. The first section describes theoretical knowledge development since the inception of the occupational therapy profession in the United States (US) in 1917. It considers the ways in which sociocultural factors within medicine, rehabilitation and psychiatry, have contributed to shifts in the occupational therapy profession's orientation from the original concepts of occupation towards other approaches. The second section of this chapter analyses the use of theoretical knowledge in contemporary mental health practice.

Chapter 4, 'Influences on Occupational Therapy Practice in Mental Health', contextualises the research in current Australian mental health practice. The chapter begins with an analysis of the influence of Australian State and Federal Government policy environments on occupational therapists, who work in public health services, and the subsequent influences these have on practice knowledge. There is a description of the impact local health areas' implementation of these policies has on service delivery, and thus upon practice knowledge requirements of those they employ, and the role expectations of occupational therapy practitioners. The next section provides an overview of occupational therapy mental health practice and a description of the practice knowledge expectations, including reviews of the limited literature on occupational therapy practice knowledge in this speciality.

Chapter 1: Introducing the Study

Chapter 5, 'Methodology', describes the research paradigm and rationale for the research. This chapter thus provides an overview of the research strategy. It begins with an outline of the purpose of the study and revisits the research questions. I explain the rationale for the research design, the research methodology, and how these strategies were used to explore the valuing and use of different forms of theoretical knowledge by occupational therapists working in mental health practice in a regional area of Australia.

Details of the research findings are presented in two parts in Chapters 6 and 7. Chapter 6, 'Findings Part 1 —Developing Personal Paradigms and Theoretical Knowledge Use in Mental Health Practice', is in two sections, which describe aspects of how the participants used different forms of theoretical knowledge in their practice. I present three participants' professional histories, which represent a range of different values and use of theoretical knowledge, and its integration with other domains of knowledge in practice. Thus, the chapter illustrates participants' use of philosophical assumptions, occupation-focused models, and frames of reference derived from psychological theories. It describes how these contribute to personal frames of reference.

Chapter 7, 'Findings Part 2 — Developing Professional Resilience on Theoretical Knowledge Use', presents the ways two discourse dimensions, dominant discourses, and practice knowledge dimensions, contribute to the value and use of theoretical knowledge. It considers the dominant discourses and occupational therapists' use of knowledge and considers socioecological and sociocultural factors. Chapter 7 presents the findings which illustrate the role of professional resilience in supporting the participants' use of different occupational forms of theoretical knowledge. It presents the strategies participants employed to maintain occupation-based practice and which appeared to support and enhance professional

Chapter 1: Introducing the Study

identity. It describes social norms derived from, and sustained by, occupational therapy communities of practice identified in the thesis.

Chapter 8, 'Discussion', is an in-depth critical discussion of the role of theoretical knowledge in occupational therapy mental health practice. This discussion integrates and synthesises the data. The relevance of these findings to occupational therapy mental health practice is discussed. There is also a reflection on the quality of the research and its implications for education, occupational therapy mental health practice and future research. Chapter 9 draws together the study's conclusions and the ways in which they contribute to the knowledge of what influences occupational therapists' use of theoretical knowledge in mental health. There is a summary of the implications of the findings on the educational needs of occupational therapists, and for those who employ and manage occupational therapists in the mental health workforce. This is a relatively unexplored area of occupational therapy practice and this chapter also proposes future areas of research.

Conclusion

My aim in this research was to gain a deeper understanding of the nature of the integration of different forms of theoretical knowledge in mental health occupational therapy practice. The purpose was to inform the profession. To do this, I employed narrative inquiry to illuminate practitioners' perceptions about the theoretical knowledge they value and use in practice and allow their voices to be analysed, interpreted and heard in the debate. The thesis differs from other research studies as it focuses on how practitioners integrate theoretical knowledge into their practice knowledge in mental health practice. It reviews how practitioners' sociocultural contexts shape the theoretical knowledge they value and use. It owes factual and interpretive debt to the work of Trevithick (2008) whose

typology I have adapted to structure the data analysis and discussion. In other respects, this work has benefitted from both Foucault's (1980) concept of dominant discourses and Habermas' (1972) way of examining knowledge categories as these allow practice knowledge in the health professions to be reviewed with reference to power relationships and social norms. The thesis explores how the social norms in communities of practice to which an occupational therapist belongs, shape their choice and use of different forms of theoretical knowledge and shape practice. The study builds on and contributes to the work into practice knowledge in occupational therapy. As such, this study provides additional insight into how occupational therapists in mental health use and value occupation-focused models and psychological frames of reference. It provides insight into the conceptual and instrumental role occupation-focused models play in paradigm-dependent practice. It illustrates the reasons why occupational therapists in mental health may turn to frames of reference drawn from psychology, to address specific service-users' issues in their practice.

CHAPTER 2: PERSPECTIVES ON PROFESSIONAL PRACTICE KNOWLEDGE

The review of the background literature is presented in three chapters. Chapter 2 reviews the different perspectives and theoretical frameworks used to analyse and describe professional practice knowledge in the health and social care professions. It continues with the conceptual frameworks adopted to explore the relationship between practice knowledge and power relationships, considers what it is that influences professional education, and describes how dominant discourses in mental health may impact on the knowledge practitioners value and use in practice (Bernstein 2000; Delanty 2001; Foucault 1980). It also includes a synoptic overview of the philosophy of knowledge moving from Aristotle to the present. This chapter also analyses different forms of theoretical knowledge with examples being given from occupational therapy.

Chapter 3 reviews theoretical knowledge in the occupational therapy profession. Chapter 4 then situates this study in the context of contemporary Australian mental health practice, and occupational therapy practice within it.

To identify the literature for Chapters 2, 3 and 4 of this review CINAHL, SOCSOI, Education databases, MEDLINE, and the search facility within Google Scholar were searched to identify literature from education, health, and social care. The key terms: practice knowledge, practice wisdom, occupational therapy, mental health, psychiatry, psychosocial practice,

education, theory, and theoretical were initially used in this search. The search was extended to include policy, recovery, medical model, and psychological theories. Searches continued throughout the duration of the research.

Defining Practice Knowledge in Health and Social Care

The status of a profession is based upon three key characteristics: its defining domains of practice, the existence of a unique knowledge base, and its ethical standards (Osmond & O'Connor 2004). Consequently, each profession is a 'knowledge-based' occupational domain with its own idiosyncratic language (Dingwall 2008; Smeby 2007). In health and social care, this knowledge base is a blend of diverse forms of knowledge, which create an individual practitioner's professional practice knowledge (Eraut 2007; Higgs et al. 2008). In addition, Trevithick (2012) proposed a unifying professional practice typology which was originally developed within social work practice (see Figure 2.1). I believe it also has relevance to occupational therapy. This framework included three knowledge domains: theoretical, factual, and practical. For clarity, I have summarised the knowledge domains identified by Trevithick and other sources in Table 2.1 and have provided generic and occupational therapy examples which fall into each domain (Brown 2003; de Cossart & Fish 2005; Fish 1998; Higgs et al. 2008; Osmond 2006; Trevithick 2012).

Table 2.1: Forms of knowledge in professional occupational therapy practice

Forms of knowledge	Example	Examples from occupational therapy
Factual Knowledge	Codified, or propositional knowledge, i.e., research-based knowledge.	Mental health knowledge. Psychological research. Classification of mental illnesses. Knowledge of policies e.g., State Mental Health Acts.
Practical Knowledge	Methods, skills, and techniques. Practical experience. Process, or procedural knowledge.	Design and implementation of task-based and other forms of therapeutic groups. Clinical OT practice experience.
Personal Knowledge	Intuition. Personal impressions. Subjective interpretations. Cumulative experience. Experiences of health systems. Life events and personal experience of occupation in own life.	Drawing on life experience when dealing with service-users' issues. Drawing on practice-based experience when choosing interventions.
Professional Knowledge	Concepts from the contemporary (occupation-based paradigm): Philosophical assumptions regarding the relationship between occupation and wellbeing. Occupational science.	Use of occupation as a means of enabling engagement and participation in daily life.
Service-Users' Knowledge	Social and cultural environment: Illness beliefs and experiences. Adaptation techniques employed to cope with illness experiences.	Strategies used to cope with symptoms. Expertise about illness experience.
Theoretical Knowledge	Discipline-based theories and concepts. Frames of reference, or borrowed knowledge from other disciplines.	Occupation-focused models. Frames of reference for example, behavioural and cognitive-behavioural.

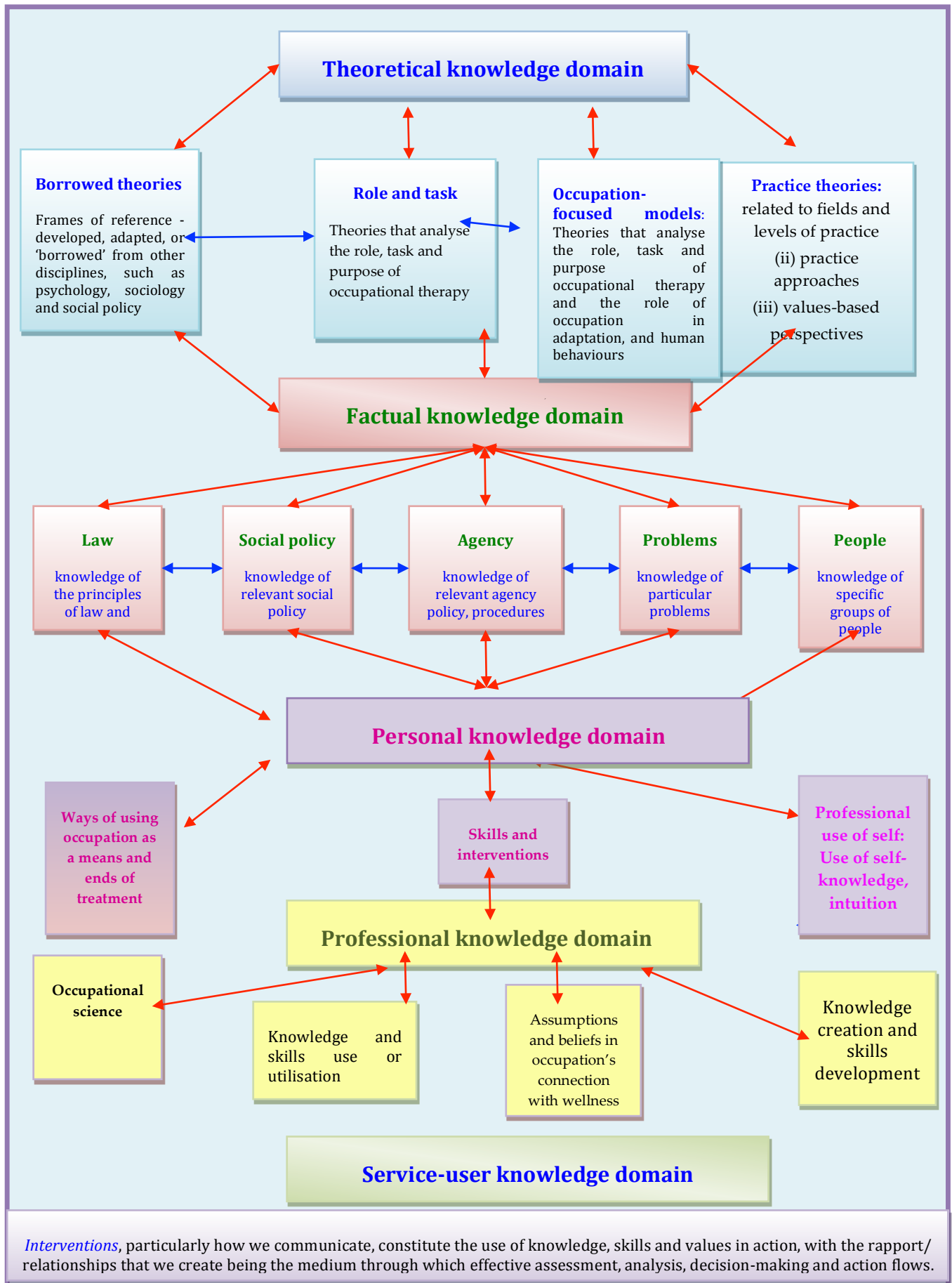


Figure 2.1: 2.1 An adaptation of Trevithick's (2012) unifying professional practice typology

Chapter 2: Perspectives on Professional Practice Knowledge

According to Eraut (2007), a professional's practice knowledge is always an integration of codified or propositional knowledge, and non-propositional knowledge, i.e., knowledge generated largely from experience. Higgs, Jones and Titchen (2008) defined propositional knowledge as that generated formally through research and scholarship: 'It includes scientific knowledge (from the sciences), aesthetics (from the arts) and logic (from philosophy)'(p. 154). The above authors categorised propositional knowledge as the 'knowing that' driven by policies governing specific areas of service provision, limitations as dictated by organisational functioning, and service-user needs relating to the illness experience. Propositional knowledge is publicly available, objective in nature, and often derived from research. This knowledge forms the basis for analysing problems in terms of pathology and illness and it enables practitioners to interpret assessment results.

In practice, propositional knowledge is integrated with non-propositional knowledge, which includes practical knowledge or the 'how to' knowledge that derives from practical experience. It also includes process and procedural knowledge – technical skills and aspects of professional behaviour (Sefton 2001). A practitioner's personal knowledge comprises personal impressions and experiences, and subjective interpretations unique to each individual.

Theoretical knowledge forms another domain which some authors (e.g. Higgs, Jones & Titchen 2008) sometimes categorise as propositional knowledge. It provides a 'knowing why' dimension to practice and is, therefore, largely explanatory. In occupational therapy, theoretical knowledge consists of discipline-based theories and concepts, and theories and concepts borrowed from psychology, psychiatry, and allied health disciplines.

Chapter 2: Perspectives on Professional Practice Knowledge

The following section provides various perspectives on knowledge development, including historical, sociocultural, and structural perspectives before considering how practice knowledge has been analysed in the occupational therapy literature. The various ways knowledge has been characterised are summarised in Table 2.2 below.

Table 2.2: Various Classifications of Knowledge

Originator	Classification	Meaning
Aristotle	Techne. Theoria. Praxis. Episteme Phronesis	Technical. Theoretical. Practical (wisdom through experience). Factual, universal, context independent Practical wisdom
Ryle (1949)	Knowing 'that'. Knowing 'how'.	Factual. Practical.
Habermas (1972)	Empirical-analytic. Historical-hermeneutical. Emancipatory.	Scientific – factual. Problem-solving. Critical reflective.
Schön (1983)	Technical rationality. Reflective practice. Knowing in action.	Technical knowledge. Professional. Experiential. Practical. Artistry.
Higgs and Titchen (2002)	Propositional. Personal. Professional – craft.	Knowing 'that' includes normative, procedural, and theoretical knowledge. Experiential. Artistry.

Historical Perspectives on Practice Knowledge: An Evolving Praxis

There has been ongoing scholarly debate about the ways different forms of knowledge are integrated in professional encounters and inform occupational therapy practice. Since ancient times, scholars have proposed methods to explain how professional practice and practical action unfolds. The Greek philosopher, Aristotle, is widely acknowledged as having a continuing influence in the study of practice knowledge. His work is a useful antecedent to later explanations of practice knowledge as his writings have influenced those interested in epistemology or the philosophy of knowledge, including Jürgen Habermas (referred to later in this chapter). Aristotle's ideas relate to how practice unfolds and the ways knowledge use is dependent on the actions, roles and tasks of professionals (Hughes 2001). According to Aristotle, disciplines can be divided into three categories: theoretical (*theoria*), technical (*techne*), or practical (*praxis*). These divisions are derived from his observations of how each discipline makes the decisions which influence their practical actions, referring to this professional reasoning and decision-making process as *praxis* (Hughes 2001a).

Praxis, or the practical reasoning behind the choices we make about what to do and how to do it – practical action – is based upon the way in which a discipline uses its factual or technical knowledge and skills – '*techne*' – and its theoretical knowledge – '*theoria*' (Hughes 2001). *Praxis* is a process of constant interaction which involves moving between the '*what*' – the knowledge that informs the process – and the '*how*' – the practical action or doing. *Praxis* or practical action involves the translation of factual or technical and theoretical knowledge into practice. Hughes (2001a) suggests that Aristotle considered the main difference between artisans and professionals is artisans use technical-rational decision making to solve a

concrete problem, whereas professionals apply diverse forms of knowledge to solve complex problems. The solution to concrete problems is technical and involves the machinations of objects which work in a particular way, whereas the solutions to complex problems are not evident in this way, but require complex reasoning processes, and wise judgements to guide decisions and actions. Aristotle describes the application of wise judgements as *phronesis* (Kinsella & Pitman 2012).

Phronesis or 'practical wisdom' is the prudence and capability of a person to consider a mode of action and to deliver change in order to enhance their quality of life or personal wellbeing (Hughes 2001a). Thus, for Aristotle, *phronesis* is the wisdom involved in integrating forms of knowledge with technical-rational skills. *Phronesis* is not simply a skill. It involves the ability to reflect upon 'how' one might achieve a certain end, and the ability to reflect upon and determine the right ends to pursue. It is concerned with particulars and contextual details because how to act in a certain situation varies (Kinsella & Pitman 2012). While practitioners can learn the principles of action and apply them in the real world, in situations they cannot foresee, they require experience of the world and moral knowledge, for Aristotle's knowledge categories imply knowing the right thing to do (Hughes 2001). For him the knowledge we use and the decisions we make are necessarily ethical decisions. Thus, *phronesis* is an integration of these various forms of knowledge to achieve a morally correct – fair or just – outcome in the particular situation (Hughes 2001a).

Professional decision making is of this nature and Aristotle's ideas on *praxis* and *phronesis* have influenced modern definitions and conceptions of professional practice, with *praxis* often referred to as 'the artistry of practice' (Paterson, Higgs & Wilcox 2005, p. 409). In the health and social care literature *praxis* is also referred to as professional craft knowledge (Higgs, Jones & Titchen 2008) or practice wisdom (Dybicz 2004). A practitioner's *praxis* comprises the lessons, from past experiences with

other service users, applied to an individual service-user's present situation and context. Without the use of this practice wisdom, professional practice can become formulaic, following a recipe-based or cookbook style of practice – or technical – rational approach (Dybicz 2004). Schön (1983) argued this type of practice negates professionalism as it leads to a technical, skill-based non-professional culture which lacks artistry.

In the health professions, praxis and phronesis have been explored in relation to research into clinical and professional reasoning (Schell & Schell 2008). In occupational therapy, this began in the 1980s (Rodgers 1983) and was built on by Mattingly and Flemming (Fleming 1991a; Fleming 1991b; Mattingly 1991a; Mattingly 1991b; Mattingly 1994; Mattingly & Fleming 1994). This body of work expanded professional knowledge regarding occupational therapists' praxis and phronesis. They described the role of reflection-in-action and reflection-on-action (Argyris & Schon 1974; Schön 1983) in articulating the tacit, or unconscious, dimensions of occupational therapy practice. While professional reasoning studies have focused on unraveling the threads involved in practical reasoning, this previous research did not focus on how different forms of theoretical knowledge impact on practitioners' practical actions. Kinsella and Whiteford (2009) argue a lack of studies into this aspect of practice has resulted in little being known about how knowledge is integrated into occupational therapy practice, and how it influences practical actions. Central to this thesis is an exploration of how occupational therapists in mental health practice value and use theoretical knowledge to shape their practice.

This thesis explores the ways in which different forms of theoretical knowledge are integrated into the praxis and phronesis of a group of occupational therapists working in Australian mental health practice, and how they might be seen to contribute to professional behaviour, decisions, and actions. The literature also suggests actions are socioculturally shaped and it is to this aspect the discussion now turns.

Sociocultural Perspectives: Contextually-Shaped Knowledge

The work of German philosopher Jürgen Habermas (1972) offers a particular way of examining knowledge categories. Habermas proposes humans come to know the truth based on their cognitive interests (Gray 2010). Hence, humans need and use different types of knowledge for different purposes. Habermas describes three types of knowing and corresponding knowledge: (i) empirical-analytical knowing or scientific or technical knowledge; (ii) historical-hermeneutic knowing or practical knowledge; and (iii) emancipatory knowing or reflective knowledge. In his definition of these three types of knowledge, Habermas (1972) places ‘empirical-analytical knowing’, or science, within the objective realm dominated by facts and certainties that, if applied to one person, can be applied to all. In contrast, he suggests that ‘historical-hermeneutic knowledge’ is context-specific. This recognises the historical nature of knowledge which changes and develops over time as humans attempt to learn from solving particular problems in the ‘here and now’. This requires the application of practical judgement based on experience and, while experience is important, it alone cannot determine the present solution. Thus, for practitioners, each new interaction raises more questions, and possibilities, and novel ways of doing things. Habermas (1972) argued that emancipatory knowing is introspective and based on self-reflection or self-knowledge. He meant this in the sense that only individuals can know whether or not their actions matched their intentions. This knowledge is emancipatory in the sense that ‘the truth shall set you free’ – there is a special kind of integrity when individual behaviours match personal values and beliefs (Edgar 2006; Ewert 1991; Gray 2010; Habermas 1972; Kitchenham 2008).

Habermas described how practical knowing, or our 'ways of doing things', is based on sociocultural norms, where a consensus of ideas determines what is regarded as acceptable behaviour. Within a profession, these sociocultural norms are likely to be codified by professional organisations and embedded in what Wenger, McDermott, and Snyder (2002) describe as 'local networks' or 'communities of practice'. Hence, occupational therapists who work in mental health are likely to be influenced by the sociocultural norms of the multiple communities of practice in which are situated. These communities include their profession, the multidisciplinary teams in which they work, special interest groups, Facebook groups, list-servers and other e-communities. It may be posited that the discourses within these different communities are likely to impact on what are considered norms of practice. These communities then influence what is considered as valuable theoretical knowledge by individual practitioners (Habermas 1972; Wenger, McDermott & Snyder 2002). The influence of these sociocultural determinants of professional norms has not been previously explored in occupational therapy.

In short, a profession's cultural practices are shaped by consensus about professional norms and values. Professions are based on collectively agreed-upon values and goals (Gray 2010). The aim of critical reflection is to achieve congruence between espoused professional norms and values, and occupational therapy practice. This is made difficult where the dominant values or norms in the practice context do not cohere with the profession's values and norms. The dominant forces or social norms operating in the workplace are likely to be influenced by each occupational therapist's constant interactions with interdisciplinary colleagues whose sociocultural norms and values might differ. This can lead to the development of shared knowledge, and tacit understanding, or, at the other extreme, explicit disagreements and interprofessional tension and conflict. Consequently, practitioners may be more likely to draw upon knowledge,

which is directly relevant to their particular practice context, and coheres with the dominant norms of practice. The knowledge from professional education, or the codified knowledge found in textbooks, or professional 'position statements' created by professional organisations would have varying utility in direct practice.

Habermas' (1972) emancipatory knowledge, however, is personal knowledge reached through critical reflection and concerns the degree of congruence achieved between the values one espouses and one's actual behaviour (Gray 2010). Only the individual practitioner can know if what he or she does conforms to what he or she believes. However, occupational therapists' self-knowledge is likely to be reliant on their awareness of, and reflection on what they know, believe, and value. Nevertheless, this is shaped by their profession's espoused norms, values, and perspectives promoted in textbooks, professional literature, ethical codes, and practice guidelines. Eraut (2007) refers to this as 'propositional knowledge', referring to the propositions on which the profession is based or what gives it its *raison d'être*. Frequently, however, professional knowledge of this sort is shaped by academics, researchers, or scholars in the discipline and can have variable relevance to practice. It is passed on to students through professional education curricula required for entry into the profession (Ashby & Chandler 2010). Professional education, then, is a process of acculturation or socialisation into the values and practices of the profession and its view of the world. Education programs, too, can have variable relevance to the workplace or practice community. For example, in occupational therapy, although client-centred practice is a core 'way of doing' occupational therapy, it is not universally adopted within particular workplaces (Hammell 2007).

Another sociocultural perspective which analyses the social norms shaping practice was provided by Wenger, McDermott and Snyder (2002), who describe the implications of communities of practice, i.e., the professional

networks, organisations, and individuals comprising professional reference groups. They define communities of practice as:

Groups of people who share a concern, a set of problems, or a passion about a topic, and who deepen their knowledge and expertise in this area by interacting on an ongoing basis ... these people don't necessarily work together every day but they meet because they find value in their interactions (p. 4).

As communities of practice accumulate knowledge, they become bound informally by the value they find in learning together and sharing tacit understanding. Wenger, McDermott and Snyder (2002) critique some communities of practice, which resist new knowledge. In these tight communities of practice, assumptions can go unquestioned or there might be little willingness inside the community to challenge them (Wenger, McDermott & Snyder 2002).

In contemporary healthcare, the concept of communities of practice is used to analyse and develop practice approaches (Jiwa et al. 2011; Lees & Meyer 2011; Valaitis et al. 2011). Within occupational therapy, Whalley Hammell (2009a, 2009b) has argued that tight communities of practice have resulted in a lack of critique about many of the assumptions underpinning professional philosophy.

Structural Perspectives: Power Relationships in Practice

While the work of Habermas (1972) and Wenger, McDermott and Snyder (2002) offer a sociocultural perspective from which to explore practice knowledge, neither considers the power relations between competing communities of practice which health and social care professionals are likely to experience. The public health system is riven with competing sociocultural environments and communities of practice. Foucault's (1980) concept of dominant discourses is helpful in exploring how the experience of power relationships within mental health practice, multidisciplinary professional teams, and the differing discourses within the occupational

therapy profession influence what practitioners value and what they consider valid and useful theoretical knowledge, and how these discourses influence practice.

Foucault (1980) used the term 'power/knowledge' to connect knowledge and power with the identity configurations associated with disciplines and professions. He was particularly interested in historical analyses of the ways in which particular discourses become dominant, and the power dynamics operating, in these processes. Within occupational therapy, Mackay (2007) used Foucault's ideas to explore how practice discourse comprises languages and practices allowing occupational therapists to be 'visible and distinguishable', and reveal the processes 'through which the dominant discourses about the occupational world come into play' (p. 97).

Perspectives of Knowledge Use in Health and Social Care

In modern times, philosophers Gilbert Ryle (1949) and Jürgen Habermas (1972) have built on Aristotle's ideas. Within the health professions, practice knowledge is often conceived using concepts proposed by Ryle (1949) in his seminal work *A Concept of the Mind*, where he attempted to distinguish between 'knowing that' – propositional knowledge or theory – and 'knowing how' which relates to technical practice knowledge and practical skills. As an 'Oxford Philosopher', Ryle (1949) argued that all philosophical concepts, including the philosophy of knowledge, could be described using language. His classical distinction between 'knowing that' – propositional knowledge or theory, and 'knowing how' – procedural knowledge – has been related to healthcare professionals' practice and practical skills (Higgs & Titchen 2001; Smeby 2007). Smeby (2007) argued this idea resonates for health care practitioners because the proposed divisions reflect that professional practice is composed of 'a cluster of aspects including phenomena that are only or mainly possible to learn, critique, or disseminate and articulate through action' (p. 209). While Fish

and Cole (2005) named 27 different forms of practice, Higgs and Titchen (2002) identified three forms of knowledge individual practitioners bring to professional practice: propositional, personal, and professional. They consider all three dimensions necessary for sound and responsible clinical reasoning.

Personal knowledge refers to the knowledge practitioners acquire from experience and comprises their personal frames of reference: the associations, concepts, values, feelings, beliefs, cognitive heuristics or conditioned responses they make, often unconsciously (Higgs, Jones & Titchen 2008). Schön (1983; 1987) talked about the role of reflection in allowing professionals to become aware of the reasons for their choices, decisions, judgements, and actions, which leads to the ability to articulate them to others. Our 'personal frames of reference' are the structures of assumptions through which we view the world and make sense of our experiences. These frames of reference selectively shape and delimit our expectations, perceptions, cognitions, and feelings (Mezirow 1991). In professional situations, practitioners use their personal knowledge to understand, engage with, and situate problems within the service-user's world. Often, but not always, a practitioner's personal knowledge coheres with his or her professional knowledge.

Research has not focused on the nature of knowledge used in occupational therapy practice, or how theoretical knowledge informs practical actions (Kinsella & Whiteford 2009). Thus, little is understood about how practitioners' personal frames of reference, which include their values and beliefs, affect their choice between different forms of theoretical knowledge in direct practice (Schell & Schell 2008), or how practitioners may be struggling to stay true to their personal and professional values in increasingly hostile or impersonal practice environments (Gray 2010). Kinsella and Whiteford (2009) identified the progress of practice

knowledge in occupational therapy as a process requiring further investigation.

Classifying Theoretical Knowledge

Within the field of social work Fargion (2007) has noted the uneven development of theoretical knowledge which has led to a proliferation of theoretical perspectives with different scholars favouring particular perspectives, often using different terms for the same concept. This creates a layering of complexity of theoretical language defining diverse theoretical terms. Fargion (2007) explores the difficulties faced by practitioners when attempting to articulate the theory used in practice, and identifies the complexity of language used to describe theory still causes confusion. Additionally, the self-referential nature of the language of theory may sustain the interests of academics rather than practitioners.

This issue has been taken up by occupational therapists, with the focus of discussions based on the use of terminology (Creek & Feaver 1993; Kortman 1994; Krefting 1985; Nixon & Creek 2006). Discussions of theory in occupational therapy describe the difficulties created by the use of terminology (Kortman 1994; Krefting 1985). In 1977, in response to noted differences in terminology used in entry-level programs, the Accreditation Committee of the American Occupational Therapy Association requested 'schools of occupational therapy' to provide statements about 'conceptual models and frames of reference' (Conte & Conte 1977). These statements were then analysed, with a noted 'apparent and rather extreme difference of opinion as to what is meant by the terms' (Conte & Conte, 1977, p. 262). They found the term 'frame of reference' was used interchangeably with the term 'concept', although they do not mean the same thing. However, continuing confusion is problematic as it creates difficulty in articulating theoretical knowledge. As noted by Krefting (1985), although 'clinical

practice and our practical actions are the visible expression of the profession, competent practice is dependent upon a sound theoretical base' (p. 174). Others like Kortman (1994) have suggested the definition of the different forms of theoretical knowledge used in occupational therapy should be based on their application in practice. However, few studies have attempted to learn more about how theoretical knowledge is synthesised and applied by practitioners so Kortman's (1994) approach to defining theoretical knowledge by its use has not advanced. It is important to learn more about how different forms of knowledge are integrated in practice as the development of theoretical knowledge will only be valued by practitioners if they are clear about its clinical utility (Kortman 1994).

Grand Theories or Meta Models

Traditionally, the classification of theories depends on what they seek to explain. For example, 'grand theories' or 'meta models' (Mills 1959) attempt to explain more or less everything in society by drawing on abstract conceptualisations, scientific theories and research. For example, Marxism is a grand theory offering an explanation of the underlying causes of oppression and social inequalities. Midrange theories explore a limited range of one or more phenomena, for example occupational behaviours, they do not seek to produce specific therapy approaches (Merton 1963).

Discipline-Based Theories: Occupation-Focused Models

Since the profession's inception, occupational therapists have been developing their theoretical knowledge base (Kielhofner & Burke 1977a). In the 1970s and 1980s the call for a renewed focus on occupation coincided with the development of discipline-based theories known as occupation-focused conceptual practice models. Table 2.3 details the occupation-focused models developed since the 1980s.

Table 2.3: Occupation-focused models

Name of Model and Authors	Year of initial publication	Country
Model of Human Occupation (Kielhofner & Burke 1980)	1980	USA
Cognitive Disabilities Model (Allen 1985)	1985	USA
Activities Health (Robinson & Cynkin 1990)	1990	USA
Adaptation through Occupation (Schkade & McClung 2001; Schkade & Schultz 1992)	1992	USA
Ecology of Human Performance (Dunn, Brown & McGuigan (1994)	1994	USA
Life Style Performance Model (Fidler 1996)	1996	USA
Canadian Model of Occupational Performance – Engagement (Canadian Association of Occupational Therapists 1997; Canadian Association of Occupational Therapists 2002)	1997	Canada
Occupation Performance Model (Australia) (Chapparo & Ranka 1997)	1997	Australia
Person Environment Occupation Performance (Christiansen and Baum 1997)	1997	USA
Kawa Model (Iwama 2006)	2006	Japan

While occupation-focused models are informed by psychological theories their primary goal is to develop a better understanding of occupation's centrality to wellness (Turpin and Iwama 2011). They explain or predict occupational behaviour, occupational adaptation, and occupational performance and engagement. They are thought to sustain professional values and occupation-based practice, comprising, as they do, discipline-based theories translated into occupation-focused models. However, Iwama (2003) argued that the development of the majority of occupation-focused models has largely represented Western epistemologies of wellness with occupation-focused models such as the CMOP and MOHO construing

the self as being at the centre of all concerns. This critique led to his development of the Kawa Model (Iwama 2006) that is founded on East Asian and Indigenous worldviews.

These models offer guidance for the process and practice of occupational therapy (Duncan 2006). Their use is thought to support professional identity because they provide occupational therapists with discipline-specific knowledge and practices and a framework within which to describe their practice (Haglund et al. 2000). Occupation-focused models are also thought to encourage practitioners to adopt occupation-based practice interventions. However, their use in practice requires further research with only limited research into the use of the Model of Human Occupation (MOHO) (Kielhofner 2008) by practitioners (Haglund et al. 2000; Lee et al. 2012; Lee et al. 2008).

In mental health practice, occupation-focused models are thought to be used by practitioners to interpret how mental illness affects a person's engagement in their chosen occupations (Farhall et al. 2007). These theories may also be used to provide strategies to assist the person's maintenance or improvement of occupational performance in their chosen leisure, productivity, and self-maintenance occupations.

Kielhofner (2004) suggested that occupation-focused models, such as the MOHO and Canadian Model of Occupational Performance and Engagement (CMOPE) (Canadian Association of Occupational Therapists 2002; Townsend & Polatajko 2007), should be termed 'conceptual models of practice' because they provide frameworks to guide practice but do not specify treatment approaches or interventions. This description places them in the category of middle-range theories. For example, the CMOPE and other discipline-specific models are intended to define the scope of occupational therapy practice as represented in Figure 2.2. However, little

is known about the value placed upon these models, or specifically, about their use by occupational therapists in mental health practice.

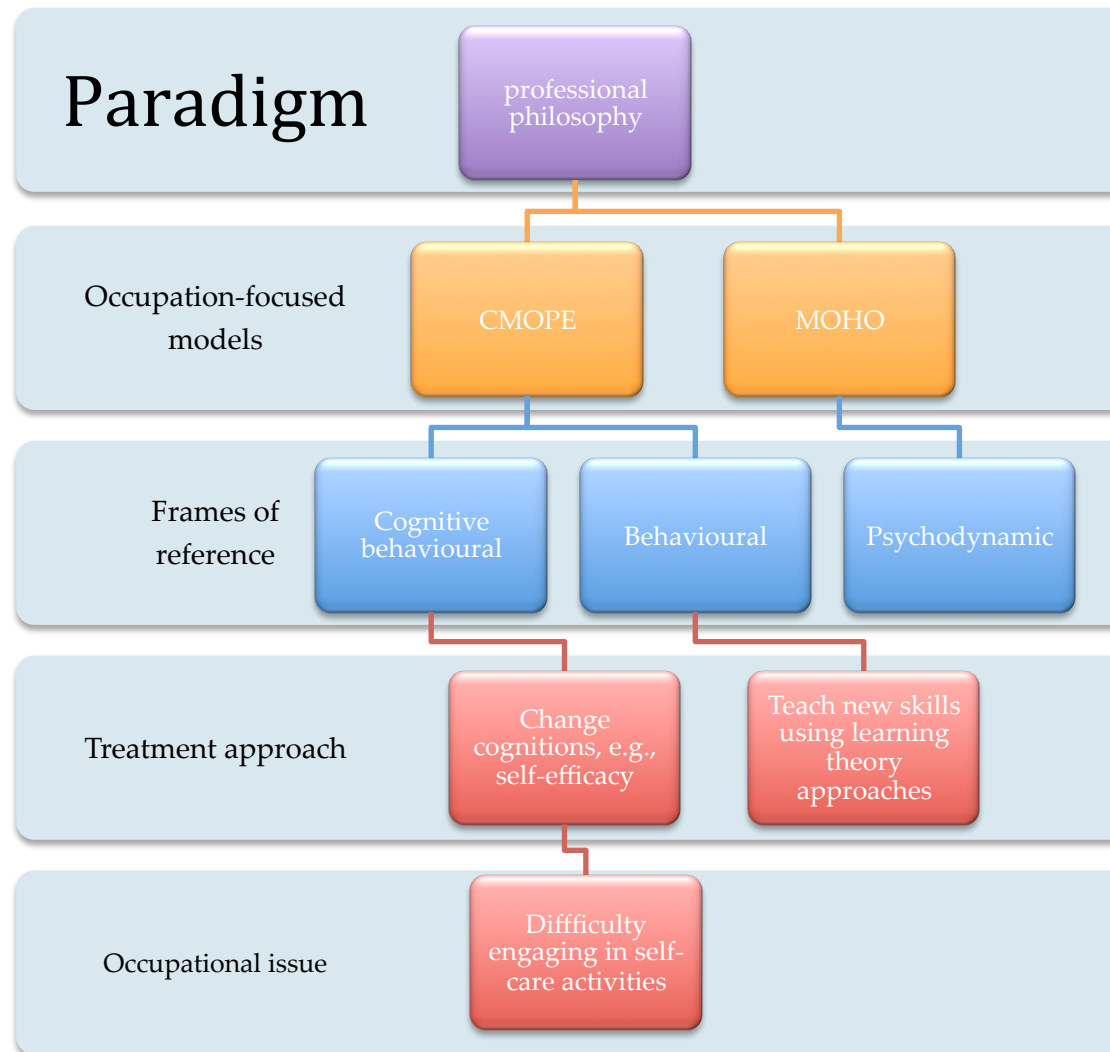


Figure 2.2: An example of codified knowledge in occupational therapy (Ashby, 2010)

These occupation-focused models reflect the influence of the ecological or biopsychosocial perspective with its balancing of the person and the social environment (Christiansen & Baum 1997; Dunn, Brown & McGuigan 1994). While often unstated, these models adopt a social ecological analysis of human occupation, and acknowledge the complexities of the relationship between people and their social environment (Schweiger & O'Brien 2005). In occupational therapy, this includes a person's engagement in occupation, and occupational experiences which occur in the environments described by Bronfenbrenner (1979) (see Table 2.4).

Table 2.4: Levels of environment named in social ecological theory, with examples from mental health-adapted from Bronfenbrenner (1979)

Level of environment	Example from mental health practice
Microsystem	<i>The structures the person has direct contact with – encompasses the relationships and interactions a person has in his or her immediate surroundings.</i>
Mesosystem	<i>Provides a connection between microsystem and the broader community, such as mental health services, friends and colleagues.</i>
Exosystem	<i>The exosystem defines the larger social system in which the person does not function directly. The structures in this environment impact on a person's engagement by interacting with the mesosystem, such as service-delivery models, community-based service models and case managers' responsibilities, which are likely to impact on a person's recovery journey from mental illness.</i>
Macrosystem	<i>The macro system includes the outermost layer in the person's environment – cultural values, customs, and legislation governing mental health services.</i>
Chronosystem	<i>Encompasses the dimension of time as it relates to the person's environment and includes developmental changes, which occur with ageing, and also the timing of external effects which can impact on wellness, such as bereavement and homelessness.</i>

While occupational therapists may consider service-users' experiences within the context of the macro, meso and microsystems in their social environment, this is not well articulated in current occupational therapy theoretical knowledge. Thus, this consideration may be an unconscious omission. For example, within mental health, occupational therapy practice is often focused on the service-users' mesosystems. Goals are focused on improving service-user's subjective wellbeing through the enhancements of abilities to carry out life skills, allowing them to remain in their chosen mesosystem, and to improve contact with others in their social environment. The social ecological model can also be used to better understand the issues contributing to, practitioners' self-chosen theoretical knowledge as they progress through their careers.

Using Occupation-Focused Models in Occupational Therapy Practice

While Australian occupational therapists are likely to have autonomy over their choice to use occupation-focused models, some health areas in the UK have adopted a particular occupation-focused model for use across occupational therapy regional services (Boniface et al. 2008; Melton 2006). This decision is justified because it is assumed the adoption of one model across a service strengthens practice by use of a common language and assessment tools. A survey of practitioners whose services adopted the MOHO, showed that the use of a common language reinforced their professional identity (Lee et al. 2012). While the benefits may outweigh the loss of autonomy, the adoption of one model is unlikely to reflect the plurality of theoretical knowledge required in a range of settings. In addition, the adoption of one dominant occupation-focused model is troublesome when there are no critical analyses of any of these models – with the only paper purporting to critique the MOHO describing only its strengths (Haglund & Kjellberg 1999). This lack of critical analysis is propagated in codified sources with book chapters usually authored by those affiliated with particular occupation-focused models. This results in a lack of objective and systematic or empirical analysis of a model's strengths and weaknesses.

Previous studies into the use of occupation-focused models are generally limited to a focus on the use of the MOHO, or mention the use of occupation-focused models as part of a wider study of practice (Craig, Chacksfield & Richards 1998; Haglund et al. 2000). For example, the use of the MOHO was researched in a survey of members of the American Occupational Therapy Association (Lee, Taylor & Kielhofner 2009; Lee et al. 2008). The response rate to the survey was less than 20%. Of the respondents, 80% reported using aspects of the MOHO, including its

assessment tools, which when used, supported holistic, client-centred, evidence-based practice. While some therapists found its concepts useful for treatment planning and intervention, others did not use the model in their practice. Lee et al. (2008) also found the majority of respondents who used the MOHO assessment tools had little knowledge of the model's theoretical underpinnings. Lee et al.s' (2008, 2009) findings suggest practitioners employ a 'recipe book' use of the MOHO, which occurs if practitioners fail to understand and appreciate the theories informing them – a style of practice critiqued by Schön (1983). He argued this type of technical-rational use of knowledge negates critically-reflective professionalism and leads to a technical or skill-based – non-professional – culture lacking in artistry. However, practitioners' use of these assessments may be based on their promotion as 'pick up and go' tools, as they are designed to be used without the underpinning theory, while targeting areas identified within it to encourage occupation-based practice. Lee, Taylor and Kielhofner (2009) concluded the main barrier to using MOHO was a lack of knowledge. They suggested increasing practitioners' knowledge about MOHO was the key to its future use. However, their study did not ask practitioners to identify whether they had used one of the other nine occupation-focused models taught in US programs (Ashby & Chandler 2010).

These studies support Hooper and Wood's (2002) analysis of the socioprofessional norms associated with occupational therapists' relationship with theoretical knowledge. These authors suggest that, for the most part, occupational therapists value knowledge which is relevant and useful for practice, i.e., they take an instrumental, pragmatic view of knowledge: Practitioners favour 'knowing by doing', especially since the connections between practice and theory are often ambiguous. Hooper and Wood (2002) argue occupational therapists view themselves as eminently practical and this defines their professional identity. Thus, occupational

therapists are likely to express and use theoretical knowledge in ways, which suit their practice setting and in line with their own experiences. In health and social care, practitioners often associate theory with 'speculation or contemplation' rather than with a systematic set of principles or methods to guide practice (Trevithick 2008a). This leads to the impression theory is linked to the abstract rather than the concrete, i.e., to practical application, and this may be alienating for pragmatic occupational therapy practitioners (Hooper & Wood 2002; Ikiugo, Smallfield & Condit 2009).

In addition, the choices made when rating theoretical knowledge against factual, personal, professional, and service-user knowledge, may also reflect occupational therapists' favouring of pragmatism. When practitioners are surveyed about the value placed on theory, this may well impact on their survey responses. This could account for the low value noted by O'Neal, Dickerson and Holbert (2007) in their study into the use of 'theoretical models' by US occupational therapists working with adults with 'learning difficulties'. They noted only 26% of the respondents stated theory was important as a guide for their daily practice, with the value placed on theory decreasing as years of experience increased. This led the authors to conclude the majority of practitioners placed a low value on theory. An alternative view is that the respondents' use of theory may have become tacit.

This discourse has led occupational therapy scholars to claim a gap exists between those who generate conceptual theory, and those engaged in practice (Forsyth, Summerfield Mann & Kielhofner 2005). This discourse is common to other health professions like nursing (Stark, Cooke & Stronach 2000). The 'gap' is usually depicted as problematic with Forsyth, Duncan and Summerfield Mann (2005), presenting a negative view of practitioners, who are considered to lack interest in their theoretical training and ignore its importance in professional practice. However, the nature of survey research means these studies were often unable to gain in-depth reasons for

responses, or to uncover all the ways in which respondents used theoretical knowledge. Thus, practitioners' rating of theoretical knowledge lower than other forms of knowledge, may not necessarily indicate its usefulness or application in practice.

In addition, the discourse of occupational therapists' reported lack of interest in, or low valuing of theoretical knowledge compared with other forms of knowledge, may simply reflect practitioners' general confusion about theory, and the variations in meanings and interpretations promulgated. It may also indicate practitioners' tacit use of occupation-focused models, or their lack of clinical utility in some practice settings.

Frames of Reference in Occupational Therapy Practice

In occupational therapy, the theories containing propositions or rationales underpinning treatment approaches are known either as practice models (Duncan 2006) or frames of references (FOR) (Krefting 1985; Townsend & Polatajko 2007). Krefting (1985) proposed frames of reference provide a bridge between theories and structure specific treatment interventions. As Turpin and Iwama (2011, p.19) noted:

The term frames of reference is favoured for theoretical systems that are not limited to the profession of occupational therapy and the term is used interchangeably with terms, such as treatment or intervention approaches because they provide a level of detail that enables their direct use in practice.

Examples of frames of reference used in occupational therapists' mental health practice include those derived from psychological theories: cognitive-behavioural, humanistic, and psychodynamic frameworks (see Figure 2.2). They contain assumptions and propositions, which underpin the treatment approaches used in practice. For example, the proposition underpinning the cognitive-behavioural frame of reference is that dysfunctional thinking and unrealistic cognitive appraisals of life events

can negatively influence feeling and behaviour (Beck et al. 1979; Beck 1995). While Eraut (1994) argued all theoretical knowledge is transformed for use in practice, the assumptions and propositions stated in the development of occupation-focused models and frames of reference remain constant (Krefting 1985).

The studies investigating the knowledge used by occupational therapists in practice are described in more detail in Chapter 3. In general, the research methodologies employed provide only a limited insight into the relationship between how an occupational therapist values and uses different forms of theoretical knowledge in practice. The connection between living with the tensions between discourses, and occupational therapists' professional identity and practice knowledge, has been explored only as an incidental or peripheral issue (Elliott, Velde & Wittman 2002; Kinn & Aas 2009). However, the identified difficulties occupational therapists have in articulating how theoretical knowledge is synthesised and integrated in personal and professional paradigms may be because its use is within the tacit dimensions of practice (Polanyi, 1966).

The Tacit Dimension of Theoretical Knowledge Use

The importance of being able to articulate the theoretical knowledge underpinning practice (Eraut 1994) is recognised within the Australian Minimum Standards for Competency for New Graduates (OT Australia 2010) yet experienced professionals may have difficulty doing this. According to Polanyi (1966) this difficulty occurs because we tend to 'know more than they can say' (p. 17). As a professional's knowledge base is extended, and practice behaviours become habitual, it can be difficult to articulate the blend of knowledge used to guide practical actions and professional reasoning. Polanyi (1966) suggested that only through reflection can this tacit knowledge be revealed. He sought to describe the 'tacit dimension of knowing' (Polanyi 1966, p. 4), or intrinsic knowledge

and cognition, and explain why 'we know more than we can say' (p.4). His work was influenced by Aristotle and Ryle. Polanyi (1966) chose to use the term 'knowing' rather than the division of 'wissen' and 'konnen' of the German philosophers, or Ryle's (1949) 'knowing what' and 'knowing how'. Rather than viewing them as separate, Polyani considered these 'two aspects of knowing have a similar structure and neither is ever present without the other' (1966, p. 7).

Tacit knowledge can be espoused through the use of reflective practice and explored in discussion (Polyani, 1966). Polyani (1966) suggests all forms of knowing can become part of a professional's tacit knowledge and require time for reflection. Without opportunities for reflection, a professional's tacit dimension of knowing and doing is difficult to express, describe, or characterise (Eraut, 1994). Evidence from education and nursing suggests asking professionals how they use and value theoretical knowledge is difficult, as much of this knowledge may be tacit (Clandinin & Connelly 2000). Those seeking to bring implicit and tacit knowledge to the surface have favoured research methods from the interpretive paradigm because they include interactive approaches to data collection which allow tacit knowledge to be elicited (Eraut 2007). Qualitative research methodologies allow practitioners to describe their tacit 'everyday' knowledge as does the use of reflection-on-action (Schön 1983) and critical reflection (Habermas, 1972). In educational and nursing research narrative inquiry has been used successfully to uncover practitioners' tacit knowledge (Clandinin & Connelly 2000; Holloway & Freshwater 2007).

There are indications the process of theoretical knowledge becoming tacit, starts occurring during entry-level programs, or soon after. Hodgetts et al.s' (2007) research into Canadian occupational therapy graduates found within two years of graduation all stated that theory guided their practice, but they could not provide specific examples of how they used it. This implies the use of 'theory' was implicit or tacit. Those graduates with less than two

years' experience were more focused on development of technical-rational skills to assist with their transition into practice (Hodgetts et al. 2007; Robertson & Griffiths 2009). The process of theoretical knowledge moving from being explicit knowledge to tacit, and the value practitioners place upon it is likely to vary depending on multiple factors, but these have not been explored in occupational therapy.

The demystification of how all forms of practice knowledge become tacit is important because a greater understanding of this process assists in understanding professional decision-making and in exploring the efficacy of practice through research. Although tacit knowledge may be uncovered through qualitative methodology, the majority of studies which have explored different aspects of occupational therapists' use of theoretical knowledge have used data from survey research only (see, for example, (Haglund et al. 2000; Lee, Taylor & Kielhofner 2009; O'Neal, Dickerson & Holbert 2007). Other studies which test practitioners' use, valuing or knowledgability about theories also used surveys (Javetz & Katz 1989; Law & McColl 1989). The conclusion of these studies has reinforced the common discourse of occupational therapists placing a low value on theoretical knowledge, but may indicate much theoretical knowledge is used tacitly.

Prior use of research methodologies based on a reductivist paradigm may have limited the opportunity to explore how practitioners translate theory into practice and differentiate between its use as conceptual, or instrumental knowledge which may be explicit, implicit or tacit (Osmond 2006). Although existing studies and opinions contribute to the occupational therapy profession's understanding of how knowledge is used in practice, these have led to the discourse of occupational therapists placing a low value on theoretical knowledge. It is my belief that it is necessary to find a means of hearing the in-depth perspectives of practitioners to better understand the processes and influences on how theoretical knowledge is valued and used in practice.

Conclusion

Though largely absent in occupational therapy practice, the in-depth analysis and use of theoretical knowledge is explored from several perspectives in other health and social care disciplines. Chapter 2 documented the search of the related literature, and how this broad range of literature might offer insight into the theoretical knowledge used and valued by occupational therapists in mental health practice. It discussed the work of some of the philosophers who have contributed towards an understanding of theoretical knowledge in this field, and stimulated debates about why different forms of knowledge become valued. The sociocultural frameworks of Habermas (1972) and Wenger, McDermott and Snyder (2002) provide additional methods for discussing the role social norms and communities of practice play in determining what practitioners consider valued knowledge.

Furthermore, Foucault's ideas of power relationships and dominant discourses offer a means of considering the power relationships between discourses which affect occupational therapists situated within mental health practice. Thus the value placed on theoretical knowledge and its use is likely to involve a relationship between sociocultural norms and the discourses in mental health workplaces. All of these contribute to an individual's decision to value or use different forms of theoretical knowledge. The subsequent nexus between theory and practice experiences is likely to be determined by a practitioner's experience of sociocultural norms, dominant discourses, and his or her reaction to these.

The use of theoretical knowledge by occupational therapists was also found in some research studies. These studies suggest that there is a gap between theory and practice because occupational therapists place a low value upon theoretical knowledge. A broadening of the initial search strategy, as documented in this chapter, revealed that research into mental health

Chapter 2: Perspectives on Professional Practice Knowledge

practice from other disciplines provided additional information about the nature of, and influences on, which forms of theoretical knowledge are used and valued by occupational therapists. This literature is discussed in Chapter 3, and explores what is known about the theoretical knowledge used by occupational therapists, specifically by those in mental health practice.

This thesis' central research questions sought to explore these issues and how different forms of theoretical knowledge inform occupational therapists' professional reasoning. Central to this is how practitioners integrate personal, professional, and factual knowledge with theoretical knowledge and how this is influenced by sociocultural contexts. This work builds on the work of Björklund (1999) and aims to provide an insight into the influence of occupational therapists' personal and professional paradigms in mental health settings.

CHAPTER 3: APPLYING THEORETICAL KNOWLEDGE IN OCCUPATIONAL THERAPY PRACTICE

Chapter 3 presents a synopsis of the literature, which reflects the historical and contemporary use of theoretical knowledge in occupational therapy practice. The first section describes the development of theoretical knowledge since the inception of the occupational therapy profession in the United States in 1917. It considers the ways in which sociocultural factors within medicine, rehabilitation and psychiatry, have contributed to shifts in the occupational therapy profession's orientation from the original concepts of occupation towards other approaches. The second section of this chapter analyses the use of theoretical knowledge in contemporary mental health practice.

Origins of Occupational Therapy

This section discusses key periods in the theoretical orientation of the occupational therapy profession. These key periods include its initial inception and occupational orientation, the shift toward rehabilitation and others forms of borrowed theoretical knowledge. This was followed by the ongoing renaissance of occupation (Whiteford, Townsend & Hocking 2000) evidenced by the emergence of the discipline of occupational science (Yerxa & Johnson 1989), along with a shift back to a paradigm-specific occupationally-focused practice (Fortune 2000).

Chapter 3: Applying Theoretical Knowledge in Occupational Therapy Practice

At its inception, the profession's aim was to have at its core the healing of both mind and body. Occupation was to be used as a curative measure, or therapeutic medium through advancing the systematic use of knowledge formation in understanding the therapeutic effect of occupation. This was supported by the idea of occupation playing an important role in healing and health (Gordon 2009).

Since 1917, occupational therapists have moved into different sectors of health, social care, community-based rehabilitation, non-government organisations, and health-promotion activities. These moves have created the necessity for knowledge to meet diverse practice needs and contexts. In health and social care, impersonal, factual knowledge is used and adapted (and even reinterpreted and recreated) to meet the specific context and needs of service users (Carr 2005; de Cossart & Fish 2005; Osmond 2006; Stark et al. 2002). The development of theoretical knowledge to underpin occupational therapy practice has reflected these needs. However, as in other health and social care professions, this development has been erratic and, in the absence of a unifying professional philosophy, it is likely practitioner's use of theoretical knowledge will depend on the interpretation of the service-user's issues, and be bound by the workplace context.

The medicalisation of the speciality of rehabilitation developed following World War I and led to a shift in occupational therapy with an increased application of theories from outside of the profession. The dissonance caused by the movement of the profession into the rehabilitation sector was documented by Friedland (1998). Friedland notes this movement saw occupational therapists drawn towards knowledge borrowed from other professions, principally from the rehabilitation model and this advocated a mechanistic model based on reductionist principles, with treatment orientated towards specific performance components. This move led to the use of theories and methods beyond an occupation focus. In turn, this

Chapter 3: Applying Theoretical Knowledge in Occupational Therapy Practice

resulted in an orientation away from the original occupation-based practice towards other forms of rehabilitation-oriented treatment focused on functional improvements. Thus, while occupation continued to be used as a 'treatment medium' the focus was on functional improvements in specific performance components with occupation used prescriptively, and not based on an individual's own interests or occupational issues. For example, weaving on large looms was used to improve upper limb strength and ranges of movement.

In the US, an awareness of this reorientation towards medicalised rehabilitation led Reilly (1962) to consider the processes underpinning the changes in the profession's practice had shifted and needed to return to the core belief in humans as occupational beings. This informed the formation of occupational science as a separate discipline from occupational therapy. In the 1980s, the emergence of occupational science, a discipline focusing on occupation, was hoped to provide benefits to the profession of occupational therapy through the development of research into occupation (Yerxa & Johnson 1989). Occupational science has a far wider remit than occupational therapy, although the profession is able to draw on its knowledge base (Pollard, Sakellariou & Lawson-Porter 2010). Occupational science and the push for occupation-based practice resulted in an emphasis in the occupational therapy literature on 'occupation' as the cornerstone of education and practice. Along with occupational science, the inclusion of occupation-focused models in the curricula for entry-level programs and in practice is also assumed to assist in the reorientation towards an occupational perspective (Whiteford & Wilcock 2001).

The discussions in occupational therapy about the move from the original occupation-based practice to a rehabilitation focus are often described through concepts proposed by philosopher Thomas Kuhn. His work on scientific and discipline paradigms (1962) has had a major influence on the language used to describe theoretical knowledge. Kuhn's ideas on scientific

Chapter 3: Applying Theoretical Knowledge in Occupational Therapy Practice

revolutions, and the notion of paradigm shifts, have influenced how occupational therapy views itself as a homogenous professional group with common values and principles forming a particular occupation-focused professional paradigm.

The notion of a universal professional paradigm existing within occupational therapy was first proposed in the 1970s by Kielhofner and Burke (1977b). Despite counter arguments from Mosey (1981) that occupational therapy was, and should remain, a pluralistic profession, and that Kuhn's notion of paradigm shifts could only usefully be applied to traditional academic fields rather than to professions, Kuhn's ideas continued to be applied by Kielhofner. Kielhofner, a US occupational therapy academic, used Kuhn's ideas to describe three professional paradigm shifts in international occupational therapy practice: (i) the original professional ethos of occupation as the focus of therapy; (ii) rehabilitation as defined in the medical model and (iii) back to occupation as a focus for practice (Kielhofner 2009; Kielhofner & Burke 1977b). He proposed these shifts occurred across international practice but he provided little evidence about how these processes occurred. Kielhofner referred to this new paradigm as the 'contemporary paradigm' (Kielhofner 1992; Kielhofner 1997; Kielhofner 2004; Kielhofner 2009). The core assumptions of the contemporary paradigm outlined by Kielhofner are: humans have an occupational nature, humans may experience occupational dysfunction, and occupation can be used as a therapeutic agent.

The evidence from practice suggests changes in practice have not occurred in the clear-cut, linear way described by Kielhofner (2009). Rather, it is influenced by context, particularly by broader changes in medical systems, as well as by policy fluctuations and cultural norms, including professional identities. The recognition of these multiple influences on practice reflect Mosey's (1985) argument for the profession of occupational therapy and its

Chapter 3: Applying Theoretical Knowledge in Occupational Therapy Practice

professional organisations to have a pluralistic rather than a monistic approach to practice. This pluralistic approach to practice acknowledges the sociocultural factors, which are likely to influence what determines clinical questions and practical actions, including what practitioners perceive as valued and efficacious theoretical knowledge. Thus, a practitioner's practical actions are likely to be influenced by their belief in the efficacy of occupation-based practice. Occupation-based practice involves the use of occupation as both a means and an end of therapy (McLaughlin Gray 1998). McLaughlin Gray (1998) proposed when occupation is used as a therapeutic medium to achieve a service-user's goal, it is used as a means. Occupation, when used as an end, is when the goal of therapy is occupationally-focused. In seeking to understand what influences practical actions and valued theoretical knowledge other theories have also been posited as described below.

Törnebohm's Theory of Personal Paradigms

In occupational therapy, Björklund (1994), a Swedish occupational therapist, has argued professional practice is more reflective of the work of Swedish philosopher Håkan Törnebohm, whose theory of paradigms provided an alternative philosophical position to Kuhn's theory (Törnebohm 1991). His theory of personal paradigms reflects a social-constructionist approach. This stance acknowledges the external influences, which affect the micro-practices involved in the application of an individual's practice knowledge. Törnebohm proposes professional paradigms are unique to particular situations, and are the result of collective context-based processes rather than universal movements. This stance acknowledges the complexity of the multiple sources, which make up practice knowledge. Törnebohm applied his theory of paradigms to occupational therapy. He distinguished between a therapist's 'personal paradigm' comprising of four mutually reinforcing components, namely: (i)

Chapter 3: Applying Theoretical Knowledge in Occupational Therapy Practice

worldview, (ii) interests, (iii) field of action, (iv) competence, and the broader professional paradigm.

Björklund (1994; 1999; 2000) dismissed postmodernist arguments about hegemonic discourses, and applied Törnebohm's philosophy, and further, questioned the existence of one overarching, scientific paradigm in occupational therapy. Inherent in Törnebohm's theory of paradigms is the notion that practitioners' personal paradigms can support, or limit, their clinical actions, depending on their level of understanding about their own knowledge, values, assumptions, and capabilities (Björklund 1999). Taking this viewpoint, Björklund (1999), argued there is a need to analyse these processes and the ways in which personal values and assumptions about propositional knowledge are affected by the social environment, organisational context, policies, and service provision, and how this affects their use in practice. Björklund (1999) suggests personal paradigms are influenced and reinforced by the lack of a collective knowledge base. While Björklund (1994; 1999; 2000) has argued a practitioner's values and beliefs contribute to what is used in practice, there have been no further studies into what influences the creation of the personal paradigms of occupational therapists in mental health practice.

The debate about pluralistic and monistic practices continues and is related to the emphasis on occupation within the contemporary paradigm. The continued use of therapies derived from other disciplines, which were intended to complement and support occupational therapy practice, has prompted some scholars to continue Friedland's (1998) argument that this orientation has led to the reduced emphasis on occupation-based practice. This has created competing discourses reflected in the ongoing debates about hegemony and pluralism within the profession (Greber 2011; Wilding 2011).

Chapter 3: Applying Theoretical Knowledge in Occupational Therapy Practice

The notion of the existence of a contemporary occupation-focused paradigm has resulted in a discourse which places the blame on individual practitioners. This is based on the belief that occupational therapists should only engage in occupation-based practice. Molineux (2011b), has added to the discourse on what constitutes authentic occupational therapy practice by drawing on Kuhn's language of paradigms. Molineux (2011) has suggested many pluralistic practices in occupational therapy result from 'practitioners working outside of the contemporary paradigm' (p.25) and in what he described as 'paradigm-independent practice' (p. 26). Furthermore, Molineux proposed practitioners should aim for 'paradigm-dependent practice that reflects the notions put forward by Kielhofner (2004) and which follow the profession's core beliefs' (p. 26) through adopting practice that is 'grounded in occupation' (p. 25). Earlier, Wilcock (1998) argued occupational therapists deviation from the 'contemporary paradigm' was because of the profession's relationship with medicine and rehabilitation. While the competing discourses may impact on a practitioner's practical actions, Törnebohm (1991) acknowledged the ways other multiple sociocultural influences affect personal paradigms, and subsequent praxis and phronesis – and hence, orientation to, or from occupation-based practice.

The impact of other discourses on practice was outlined by Greber (2011), who in a description of Australian occupational therapy practice argued that:

It is just possible, then, that in the future occupational therapy might more formally morph into two separate entities – one focussing only on repairing faulty mechanisms and the other using the complexity of human occupation to understand and develop powerful therapeutic interventions that transform lives and enhance meaning and purpose (p. 458).

Gerber (2011) supported this argument with references to occupational therapy practice in the context of acute inpatient hospitals. In these

Chapter 3: Applying Theoretical Knowledge in Occupational Therapy Practice

environments, services are limited due to inpatient stays of only two to three days. Thus, in this setting, practitioners may be reacting to the prevalent medical and rehabilitation discourses and the tight time frames, which result in the prioritising of service-user's independence in self-care over fulfilling all their occupational needs. While practitioners respond to service, rather than service-users' demands, they are likely to continue to identify professionally as occupational therapists. The core beliefs of practitioners may still remain. This was demonstrated by Wilding and Whiteford (2008) who documented the effect of an action research project to reorientate practice towards the use of the language of occupation to describe the focus of interventions. The practitioners had adopted language from the rehabilitation and medical models, but after researchers' interventions they used specific occupation-focused language to explain their actions noting its positive influences on their professional identity in the workplace (Wilding & Whiteford 2008). Later, Wilding (2011) argued occupational therapists are:

Unconsciously complicit with the medical, scientific and fiscal discourses that sometimes dominate health settings and therefore they may unwittingly contribute to the subjugation and poor representation of the profession (p. 293).

Furthermore, Wilding (2011) suggested that:

Taken-for-granted acceptance of dominant ideas may contribute to hegemony. Hegemony refers to the ways in which certain sets of ideas become established as natural and in which a dominated group actively consents in and helps to reproduce its own domination (p. 293).

While Greber (2011), Molineux (2011b), and Wilding (2011) have suggested the responsibility to enact and change practice lies with individual practitioners, other authors have taken a different position. Pollard and Walsh (2010) identified other factors which compromise the ability of the profession and individual practitioners to exercise the power required to facilitate and enable the use of occupation-focused interventions. These

Chapter 3: Applying Theoretical Knowledge in Occupational Therapy Practice

factors include the impact of male-dominated health and social care hegemonies, especially since most occupational therapists are female.

The need to critique the theoretical knowledge developments within occupational therapy and to take a more critical stance regarding the efficacy of occupation-focused models, was discussed in Chapter 2. While limited in number, critiques about some of the assumptions inherent in the occupational therapy 'philosophy' and professional trends have questioned their relevance and usefulness in practice (Hammell 2009a; Hammell 2009b; Kelly & McFarlane 2007; Mocellin 1995; Mocellin 1996). For example, Mocellin (1995) focused his critique on Reilly's (1962) assumption, commonly quoted in occupational therapy texts: 'man [sic], through the use of his hands as they are energised by mind and will, can influence the state of his [sic] health' (p. 2). Mocellin argued this belief led to the adoption of the biological and sociocultural aspects of occupation. He questioned Wilcock's (1993, p.200) statement: 'the need to engage in purposeful occupation is innate and related to ... health and survival' and further argued that the focus on unquestioned assumptions had led to the development of theoretical knowledge based on occupation and advocated that:

The process of learning and teaching of skills is a more accurate description of the process of therapy, and that the notion of health through occupation is no longer useful nor is it useful to provide the necessary foundation for the further advancement of the profession (Mocellin 1996, p.16).

The continued lack of published critical debate about philosophical underpinnings of occupational therapy led Kelly and McFarlane (2007) to describe the profession as a cult. Additionally, Hammell, a Canadian-based scholar and occupational therapist, challenged the profession's core beliefs and assumptions about the connections between occupation, wellbeing, and health (Hammell 2004; Hammell 2009a; Hammell 2009b). Hammell's perspective challenges Townsend and Polatajko's (2007) claim that:

Chapter 3: Applying Theoretical Knowledge in Occupational Therapy Practice

Some basic assumptions ... by definition are not questioned, but rather are held to be true. These assumptions are challenged only when there is a large accumulation of prevailing evidence to suggest that the assumptions are no longer tenable (p. 20).

In contesting this statement, Hammell (2009) argues that assumptions about occupation should be questioned. This need for questioning also extends to a debate on the discipline-based theories developed to date, which Hammell argued are culturally specific, contestable, and lacking in supportive evidence with underpinning assumptions of occupational therapy, which reflect only a 'Western perspective'. Rudman and Dennhardt (2008) also criticise the exclusion of differing cultural needs within occupational therapy's codified and theoretical knowledge. These critiques are significant as they are likely to impact on the perceived clinical utility of occupation-focused theoretical knowledge.

Theoretical Knowledge: Its Relationship to Changes in Professional Identity, and Language

The way occupational therapists describe their professional roles and practice has an impact, on how they are perceived by other professionals, and on their own implicit or intrinsic professional identity (Wilding & Whiteford 2008). The power of language can shape and confirm professional identity, and the control of direction and tasks. For example, there are important links between how practitioners are able to articulate the theoretical underpinnings of their interventions and the development of a research base. This notion is not new. Reed (1984) identified the necessity for occupational therapists to articulate the theoretical constructs, which underpin their practice, in order to refine and create research hypotheses (quantitative) and questions (qualitative). Egan (2003) reiterated the inextricable and important link between practitioners' abilities to articulate the theoretical knowledge underpinning practice and the ability to design

Chapter 3: Applying Theoretical Knowledge in Occupational Therapy Practice

research which adds to the profession's evidence-base. The articulation of theoretical knowledge enables the testing of assumptions proposed by Hammell (2009), and the consideration of why an occupation-based intervention works or does not, in the manner intended.

One achievement of occupational science is the creation of new specialist terms codified within the occupational therapy literature, for example 'occupational justice' (Townsend & Wilcock 2004). According to Wilding and Whiteford (2008) using language from occupational science, and occupational therapy, is important because using language from rehabilitation or biomedical vocabularies contributes to the loss of occupation-based practice. While there are benefits in the creation of specialist terms to describe practice and occupational issues, Cusick (2001) argued this increased occupational vocabulary also means that, even within the profession, fewer people may understand, or be aware of, the new occupational 'code'. Rather than assisting therapists to explain their practice to others, this new language leads to the problem of communicating 'ideas to others outside of our professional group who do not have our "occupational dictionaries" or who do not consult them' (Cusick 2001, p. 106). Hence, the development of a specific professional language describing the different dimensions of occupation potentially creates a gap between academics and practitioners, and between practitioners and service users (Canadian Association of Occupational Therapists 2002; Kielhofner 2004; Mosey 1981; Reed 1984; Townsend & Polatajko 2007). The work of Wilding and Whiteford (2008) has raised the importance of reorienting practitioners towards the use of occupation-focused language. Although debate has focused on the impact of biomedical and rehabilitation discourses in acute care settings (Friedland 1998; Greber 2011; Wilding & Whiteford 2008) there remains a need to critically evaluate the influences of psychological frames of reference and

their associated psychotherapies, on occupational therapists' mental health practice and the language they use to describe their actions.

Defining Formal Perspectives of Occupational Therapist's Knowledge and Professional Identity

It is crucial to be aware of how occupational therapy is represented in sources external to the profession because it is the view of those who influence policy and management, which determine employment and service directions. In using Bronfenbrenner's (1979) social ecological model, referred to in Chapter 2, as a reference, the policies developed at a macro (national), or mesolevel (organisational) are likely to influence the remits of practice domains and are likely to impact on the development of occupational therapists' personal paradigms (Törnebohm 1991). In turn, these are interpreted by government agencies and public health organisations at the mesoenvironment level. If there is a difference in perception between how governments or organisations understand a profession's unique knowledge base, idiosyncratic language or domain of practice, practitioners may experience dissonance in their workplaces (Dingwall, 2008; Smeby, 2007).

Internal debates in the occupational therapy profession have focused on how its unique occupation-focused knowledge base is reflected in the 'contemporary paradigm' (Molineux 2011b). The inclusion of occupation is seen as essential in the development and sustainability of occupation-based practice and the fulfilment of the profession's full potential (Kielhofner 2007; Whiteford & Wilcock 2001; Wood et al. 2000). This renewed focus has resulted in inclusion of occupation-focused language in prominent professional documents produced by authoritative organisations (World Federation of Occupational Therapists 2002). Thus, its international

Chapter 3: Applying Theoretical Knowledge in Occupational Therapy Practice

governing body, the World Federation of Occupational Therapists (2012) [WFOT], describes occupational therapy as:

A client-centred health profession concerned with promoting health and wellbeing 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 (p.4).

While the WFOT statement focuses on the goals and mission of the profession, in Australia and New Zealand those outside of the profession, who seek descriptions of professions, are likely to refer to The Australian and New Zealand Classification of Occupations (Australian Bureau of Statistics 1997) [ABS]. These classifications focus on skills, and were written more than a decade ago. In Australia they are used to collect census data, develop policy, and plan public health services. The current classification of occupational therapy is presented in Table 3.1.

Table 3.1: Australian Bureau of Statistics' (ABS 1997) classification of occupational therapy

*Assessing clients' functional potential in their home, leisure, work and school environments, and recommending environmental adaptations to maximise their performance
*Planning and directing programs through the use of vocational, recreational, remedial, social and educational activities on an individual and group basis
Providing advice to family members, carers, employers, and teachers about adapting clients' home, leisure, work and school environments
Providing adaptive equipment, such as wheel chairs and splints, to assist clients to overcome their functional limitations
Working with other health professionals in overall case management of clients
Recording clients' progress and maintaining professional relationships in accordance with relevant legislative requirements and ethical guidelines

*Profession-specific skills

These ABS documents do not reflect the past two decades' of renewed emphasis on occupation within the occupational therapy profession. This classification does not reflect the language of occupation, except the tasks

highlighted with an asterix in Table 3.1, which refer to profession-specific skills. These examples illustrate the ways a dissonance can occur between those directing services and practitioners, if people who direct and plan services refer to this older classification.

Educational Discourses in Occupational Therapy

In occupational therapy, there is recognition of the central role entry-level educational programs play in shaping practitioners' use of theoretical knowledge (Law & McColl 1989). Bernstein (2000), a British educational sociologist, identified how the knowledge entrenched in professional education can be understood through analysing who owns the knowledge – academics or practitioners – and how it is reinforced in pedagogy. In occupational therapy, while academics form part of the professional hegemony, decisions about curricula are also affected by other dominant professional and institutional discourses, which universities offering professional education, are required to take into account (OT Australia 1999; OT Australia 2010; World Federation of Occupational Therapists 2002). Thus, professional power over curriculum content is exerted through the professional accreditation process, which, in turn, influences the forms of knowledge, which become valued and used in practice. In addition, each university has its own institutional policies, which also influence curriculum content through policies and procedures, and how academics and students access and share knowledge (Delanty 2001).

It is important to note here Bernstein was influenced by Bourdieu and Passeron's (1977) seminal work. He shared their view that knowledge is power, socially located in contexts of power, which are in essence, classificatory or cognitive systems in which symbolic capital circulates. This capital is determined by what Habermas' (1972) refers to as 'social norms'. Thus, curriculum content is value laden with the explicit and implicit

Chapter 3: Applying Theoretical Knowledge in Occupational Therapy Practice

curriculum determined and controlled by academics' personal axioms and institutional requirements. In occupational therapy, Hooper (2008) has identified the ways academics are socialised within academic circles and the influence of their professional clinical experience, and personal values, and the impacts of this on the theoretical knowledge included in a program's implicit and explicit curriculum.

Studies in the 1980s found the majority of occupational therapists obtained their foundation of theoretical knowledge from entry-level or post-graduate programs (Javetz & Katz 1989; Law & McColl 1989; Van Deusen 1981; Van Deusen 1985; Van Deusen 1986). The lack of critical debate about occupational therapy theory may be due to its relatively recent development in the profession, as, until the 1970s, most education programs did not have a theoretical orientation, and were focused on technical-rational skills and treatment modalities (Conte & Conte 1977; Krefting 1985). From this time, the increased emphasis and importance of theoretical knowledge in education was reflected in the production of texts about theoretical knowledge (Kielhofner 1992; Miller et al. 1988; Young & Cenin 1992). Occupation-focused models have been included within contemporary curricula. An exploratory study by Ashby and Chandler (2010) found curricula of entry-level programs in five countries included between three to ten occupation-focused models. Ashby and Chandler (2010) found that the inclusion of occupation-focused models was mainly based on educators' perceptions of their evidence-based practice, perceived use in practice and overall familiarity with the model. These perceptions led to the privileging of the MOHO and the CMOP-E over other models with these two occupation-focused models being included in 98% of surveyed programs. However, few studies have sought to explore the relationship between entry-level education and the processes involved in the integration of theory into subsequent practice.

Chapter 3: Applying Theoretical Knowledge in Occupational Therapy Practice

It is clear from these earlier studies practitioners' value and use of theoretical knowledge in practice is likely to be understood through the analysis of the discourses endorsed by professional organisations and people involved in the design of curricula. In occupational therapy, this occurs at various levels of the profession: the World Federation of Occupational Therapists (World Federation of Occupational Therapists 2002) provides guidelines about the content of occupational therapy entry-level programs necessary for the program to be accredited. National organisations then include knowledge pertinent to regional needs and ensure the content of programs complies with the recognised core knowledge skills and abilities, which contribute to practice knowledge.

In Australia, while there are no documents delineating practice domains, Occupational Therapy Australia has produced guidelines upon which practitioners are expected to draw on in their practice, including Codes of Conduct and the 'Australian Minimum Competency Standards for New Graduate Occupational Therapists' (OT Australia 2010). These documents acknowledge practitioners are expected to draw on many sources of propositional knowledge in their practice (OT Australia 1994; OT Australia 2010) and the Australian competency standards reflect the expectations of a new graduate into the profession. The standards include the process skills, and abilities required for practice (OT Australia 1994; OT Australia 2010) which support registration and entry into the profession. While they recognise other forms of knowledge contribute to practice, graduates are directed towards achievement of these competencies 'to do', rather than competency to explain 'why', or the reasoning and knowledge informing the doing.

In addition to these standards for new graduates, there are context-specific standards, which delineate desirable and essential characteristics, and speciality skills and abilities including the ability to apply knowledge. An example is the 'Professional Competency Standards for Occupational

Chapter 3: Applying Theoretical Knowledge in Occupational Therapy Practice

Therapists in Mental Health' (OT Australia 1999). These standards document the knowledge and skills required by occupational therapists in mental health practice. It emphasises competencies based on generic skills – rather than explicitly outlining required factual and theoretical knowledge. The OT Australia competencies are codified professional knowledge, which do not 'measure' or 'test' the quality of the thinking process behind the action. The 'knowing how' is measured, but this process does not capture 'knowing what'. It can also strengthen graduates' perceived importance of the technical, process-led skills rather than on the full spectrum of practice knowledge required in professional reasoning. While unintended, a competency approach to delineating professional practice may be likely to indicate practical skills are more valued than the theory supporting their practical actions. The implication is the professional organisation producing these standards considers technical-rational skills more important than the more abstract, harder to document, praxis and phronesis, as described in Chapter 2, which should underpin visible, benchmarked, practical actions.

Impact of Educational Level on Appreciation and Use of Theory

In the 1980s, studies by Van Deusen (1981; 1985; 1986) indicated a link between an occupational therapist's level of education and knowledge of theory. However, later studies have found no connection (Lee, Taylor & Kielhofner 2009; Lee et al. 2008; O'Neal, Dickerson & Holbert 2007). Interestingly, the findings of Lee et al. (2008, 2009) differ from Van Deusen's as they did not identify differences between levels of professional accreditation. This may reflect the changes in the US education of occupational therapists in the years between these studies, when US Bachelor's entry-level programs were replaced by Master's level entry.

Chapter 3: Applying Theoretical Knowledge in Occupational Therapy Practice

However, the ways in which practitioners are introduced to theoretical knowledge during entry-level programs may influence their valuing of theoretical knowledge, and specific occupation-focused models, rather than the level of the program.

The socialisation of students in occupational therapy communities of practice takes place during the minimum 1000 hours spent on professional practice education. These practice education experiences are an essential component of the education program and an important part of the explicit curriculum (Brown, James & Mackenzie 2006; Hooper 2008). It is during practice education experiences occupational therapy students gain experiential knowledge in applying occupation-focused theory learnt in the university setting to practice situations (Banks, Bell & Smits 2000). The language used in practice by practitioners subsequently permeates into the building of practice knowledge during entry-level programs. The cycle continues as, in turn, entry-level program's theoretical knowledge content influences a practitioner's choice of theory in their future practice (Hodgetts et al. 2007; Law & McColl 1989; Van Deusen 1985; Van Deusen 1986). Thus, a practitioner's knowledge and use of occupation-focused models in practice will largely be shaped by the content of his or her entry-level program's curriculum (Ashby & Chandler 2010). It may be posited entry-level programs, no matter what the educational level, provide an introduction, to what Habermas (1972) described as social or community knowledge. In contrast, those practitioners who choose to expand their knowledge of occupational therapy via a postgraduate Master's degree program may intrinsically regard education into occupation-focused theoretical knowledge as emancipatory.

The Use of Theoretical Knowledge in Mental Health Occupational Therapy

In occupational therapy mental health practice, it is assumed a practitioner's choice of 'theory' affects how they view a person's underlying pathology and its causes, behaviours and experiences, and guides specific treatment strategies (Finlay 2004; Lee, Taylor & Kielhofner 2009; Pettican & Bryant 2007). Some scholars argue that occupation should form the basis of occupational therapy's codified knowledge and be central to the profession (Whiteford & Wilcock 2001). However, occupational therapists in mental health practice draw on various sources of propositional knowledge, each with competing assumptions: an occupational perspective (Ennals & Fossey 2007), psychological theories (Finlay 2004; Ikiugu 2007), the medical model (Nye 2003), and the recovery approach (Anthony 1993; Rickwood 2004). Previous studies have demonstrated the dominance of psychological theories within occupational therapy practice (Bartlow & Hartwig 1989; Haglund et al. 2000). Despite this, little has been done to investigate how competing perspectives, personal values, theories, and experiences impact on an individual's professional paradigm and practice (Schell & Schell 2008).

Although studies have investigated mental health occupational therapy practice in developed 'Western' contexts, only a few have included the use of theoretical knowledge within their broader research question (Craik, Chacksfield & Richards 1998; Duffy & Nolan 2005; Lloyd, King & Bassett 2002; Wikeby, Lundgren Pierre & Archenholtz 2006). Only two studies have included the use of theoretical knowledge as a central research question. These were conducted in Australia (Bartlow & Hartwig 1989) and Sweden (Haglund et al. 2000). The findings of these studies are presented in Table 3.2. Both studies used survey methodologies and focused on the identification of theories used by occupational therapists. Neither sought to

Chapter 3: Applying Theoretical Knowledge in Occupational Therapy Practice

understand how or why practitioners used theory. In the older Australian study by Bartlow and Hartwig (1989), the most widely used frames of reference were the behavioural, including cognitive-behavioural therapy (45%), psychoanalysis (38.6%), and humanism (38.6%). This compared with the use of occupational behaviour (23.9%). They suggested the increased use of discipline-based theories would lead to a unique professional framework and result in increased coherence in the definition and planning of occupational therapy services. Professional programs were the main source of theoretical knowledge with Bartlow and Hartwig (1989) concluding there was a need for an 'increased effectiveness in teaching of conceptual theories' (p.189) to increase the use of these theories in practice. Additionally, they recommended the need for more structured time and activity in the classroom, and during professional practice education, devoted to the application of these theories. These educational solutions were taken up by Wood (1996), who also suggested the focus of university programs should be on the principles and theories, which govern practice rather than on teaching skills.

Over a decade later, an exploration of theoretical approaches and practice models used by Swedish practitioners in mental health practice found 75% of the respondents did not use 'thinking based on models from their own field' (Haglund et al. 2000, p.107). The majority of respondents reported they used psychological frames of reference more often than an occupation-focused model. Similar to Bartlow and Hartwig (1989), the authors concluded the remedy for this was for occupational therapy education to place more emphasis on knowledge from its own field.

Chapter 3: Applying Theoretical Knowledge in Occupational Therapy Practice

Table 3.2: Summary of occupational therapy mental health research, which included theoretical knowledge use

Author	Year	Country	Study focus	Population surveyed	Size of Sample
Bartlow & Hartwig	1989	Australia	All occupational therapy mental health	Professional organisation members	76
Craik et al.	1998	UK	All occupational therapy mental health practice contexts	Special interest group members	137
Haglund et al.	2000	Sweden	All mental health practice	All practitioners in mental health practice	302
Lloyd et al.	2002	Australia	All occupational therapy mental health	Professional organisation members	148
Wikeby et al.	2006	Sweden	Clinical reasoning in mental health	Delphi study with 14 participants.	14
WFOT-Brintell et al.	2009	8 member countries	All occupational therapy mental health	Professional organisation members	1387
Ceramidas	2009	Australia	All occupational therapy mental health	Professional organisation members	211

Craik, Chacksfield and Richards (1998) explored the working lives of occupational therapy members of a Mental Health Specialist Interest Group. This survey included some questions about theoretical knowledge used in practice which found that of the 137 respondents, 23% reported not using any theoretical models to underpin practice, but in general, therapists used more than one model. Craik's team also noted that 50% of respondents reported the occupation-focused models they used were: the Model of Human Occupation (Kielhofner 2008) with the Canadian Model of Occupational Performance (Canadian Association of Occupational Therapists 1997), Adaptation through Occupation (Reed & Sanderson 1980)

Chapter 3: Applying Theoretical Knowledge in Occupational Therapy Practice

and Ontogenesis (Mosey 1986). Their use is summarised below in Table 3.3. In that study, respondents also mentioned the frames of reference used included: humanistic, psychoanalytical, cognitive-behavioural, problem-solving, behavioural, rehabilitative, cognitive disability, or a 'mix of all sorts' (Craik, Chacksfield & Richards 1998, p. 231).

Table 3.3: Frequency of models used by mental health occupational therapists in Craik, Chacksfield and Richards' (1998) UK study

Model/Frequency of use	Occasionally	Monthly	Weekly	Daily	Total number of therapists
MOHO	24 (35.3)	4 (5.9)	14 (20.6)	26 (38.2)	68
CMOPE	23 (63.9)	3 (8.3)	5 (13.9)	5 (13.9)	36
Adaptation through occupation	10 (30.3)	4 (12.1)	6 (18.2)	13 (39.4)	33
Ontogenesis	7 (33.3)	3 (14.3)	4 (19.0)	7 (33.3)	21

In another related Delphi study, Wikeby, Lundgren and Archenholtz (2006) reviewed 14 Swedish mental health occupational therapists' reflections on their mental health practice. These occupational therapists agreed professional theories (referred to in this study to occupation-focused models) should act as guidelines for practice. The occupation-focused model used most frequently was the MOHO, due to the perceived clinical utility of its concepts: habits, volition, roles, and environmental factors. However, they also used 'conscious use of self', the teaching process, purposeful activities, activity analysis and synthesis, activity groups proposed by Mosey (1973; 1986). These were considered by Wikeby, Lundgren Pierre and Archenholtz's (2006) participants to be legitimate tools for occupational therapists, and were used to describe how they worked, to others. Despite participants reporting their use of occupation-

Chapter 3: Applying Theoretical Knowledge in Occupational Therapy Practice

focused models, few used the associated occupation-focused assessment tools. In general, participants reported they rarely used only one theory, but 'mixed several different theories to obtain a more holistic perspective in practice' (Wikeby, Lundgren Pierre & Archenholtz 2006, p.155) . Although the theories were seen as supporting practice, there was no consensus about the importance of theories for documentation, the choice of a theoretical foundation, and the importance of an evidence-based treatment model. While participants advocated a focus on occupational issues, they did not reach a consensus about whether the focus of intervention should be the service-user's occupational performance or functional level.

The occupational therapy profession's codified knowledge also reinforces the habituated use of psychological frames of reference in occupational therapy mental health. Its textbooks describe how to use psychological frames of reference in practice rather than emphasising the importance of occupationally-focused theories (Creek & Lougher 2008; Ikiugu 2007). A 2005 survey of occupational therapists, in mental health practice working in five countries, demonstrated the prevalence of cognitive-behavioural therapy (CBT) in practice (Brintnell et al. 2005). Respondents reported they adapted CBT and clearly delineated the situations when it was or was not used. They also noted psychology colleagues viewed CBT as discipline specific and its use by occupational therapists caused conflict in the workplace. Brintnell et al.s' (2005) findings revealed the dominance of the cognitive-behavioural approach and indicated the use of these psychological theories is an accepted sociocultural norm within the occupational therapy's mental health community of practice. Each of the studies, spanning 1989-2010, concluded occupational therapists in mental health adopt theories from the dominant discourse of psychology.

These studies demonstrated the eclectic mix of psychological frames of references used by occupational therapists to guide their practical actions. If practitioners use fractured and dissonant theories due to this eclectic

Chapter 3: Applying Theoretical Knowledge in Occupational Therapy Practice

approach, this may be problematic as it influences practitioners' ability to trace the theoretical underpinning of practical actions. The adoption, interpretation, and adaptation of theory from another discipline to underpin practice may also impact on professional identity. The dominance of these psychological frames of reference in practice requires further exploration into the processes and influences of the adoption and adaptation of theoretical frameworks. This is because the extensive incorporation of psychological theories and therapies by mental health occupational therapists has implications for occupation-based practice. A reliance on frames of reference from psychology, even with judicious translation and adaptation to meet occupational issues, may lead to the adoption of treatment methods lacking an occupation-focus and thus contribute to a loss of professional identity (Pettican & Bryant 2007).

Conclusion

This chapter documented the interplay of the factors impacting on the integration of theoretical knowledge into occupational therapists' personal paradigms in mental health practice. This discussion highlighted the ways in which the occupational therapy's professional paradigm has developed, and its influences on educational discourses. It identified that while previous studies have noted the traditional use of psychological frames of reference by occupational therapists (e.g. Bartlow & Hartwig 1989; Haglund et al. 2000) there is little explanation of why a practitioner chooses one formal specialist theory over another (Schell & Schell 2008). There also remain questions on how all forms of theoretical knowledge are translated or adapted into practice and how theories 'borrowed' from other professions influence mental health occupational therapy practice. The choice of theoretical knowledge used by practitioners is likely to be significant as it can determine practitioners' use of language and the focus of interventions (Finlay 2004). The next chapter places the study in the

Chapter 3: Applying Theoretical Knowledge in Occupational Therapy Practice

context of contemporary Australian mental health practice and explores how the challenges faced by practitioners may influence occupational therapists' choice of theories (Haglund et al. 2000).

CHAPTER 4: INFLUENCES ON OCCUPATIONAL THERAPY PRACTICE IN MENTAL HEALTH

This chapter expands on Chapters 2, and 3. It begins with an analysis of how Australian State and Federal Government policy environments affect occupational therapists working in public health services, and the subsequent influences on practice knowledge. There is an analysis of the impact public health services' implementation of these policies has on service delivery, and thus upon practice knowledge requirements of those they employ, as well as the role expectations of occupational therapy practitioners.

The next section provides an overview of occupational therapy mental health practice and a description of the practice knowledge expectations, including reviews of the limited literature on occupational therapy practice knowledge in this speciality. The chapter contextualises the research topic within contemporary occupational therapy mental health practice, with practitioners who worked in one regional public health service, in NSW Australia, where this study was conducted from 2008-2011. The chapter also explores how occupational therapists' use of different forms of theoretical knowledge, in practice, may be associated with the widely acknowledged challenges and constraints associated with occupational therapy in mental health (Hayes et al. 2008; Krupa & Clark 2004; Rodger et al. 2009; Scanlon et al. 2010).

Although this research focuses on mental health practice in Australia, the chapter includes studies from other countries on knowledge use, and the

practical actions of occupational therapists in mental health practice. While there are always local interpretations of macro and micropolicies, issues relating to this professional domain and identity extend across national boundaries. There are also similarities in the delivery of public mental health services in Australia, Canada, and the UK (Ceramidas et al. 2009).

Mental Health Policy in Australia: Influences on Occupational Therapy Practice in Mental Health

In Australia during the 1960s and 1970s, there were shifts in policy away from institutional care for the mentally ill which dramatically changed service provision in this area, and placed a greater emphasis on community care (Meadows, Singh & Grigg 2007). In response to these policies, a deinstitutionalisation process occurred in NSW and other Australian States and Territories. In NSW, the process of deinstitutionalisation is often described as being incomplete (MacKinnon & Coleborne 2003; Rosen 2006a). Thus, while the majority of occupational therapists now work in the community-based mental health teams, others remain employed in hospital-based services (Ceramidas et al. 2009).

Within NSW, the Health Department is divided into eight separate regions, called Area Health Services. Within the NSW public health system, mental health services are directed by NSW Health's translation of the National Mental Health Plan (Commonwealth of Australia 2009), and other State and Federal Governments' policies. The National Mental Health Plan directs States towards the implementation of mental health services and the incorporation of a recovery approach (Anthony 1993; Deegan 1996). In NSW, this move toward a recovery approach is described in the policy strategy document 'New Directions in Mental Health' (Mental Health & Drug & Alcohol Office 2006). The Area Health Services within NSW then determine the implementation of these macro policies at a mesolevel. Thus,

to work in mental health services in NSW, all health and social care professionals require generic mental health knowledge, discipline-specific knowledge, and the ability to implement a recovery approach in their delivery of services.

Recovery is now in the forefront of the policy agenda in Australian mental health (Australian Health Ministers 2003). It was defined by Anthony (1993) as:

A deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and or roles. It is a way of living a satisfying, hopeful and contributing life. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of psychiatric disability (p. 11).

This definition has made a major contribution to the recovery orientation in psychiatric rehabilitation. However, there is no universal definition of recovery and some argue it remains a contested concept (Bonney & Stickley 2008). Rickwood (2004) suggested the Australian understanding of recovery has been derived from US recovery literature and innovative work in Canada, and New Zealand.

The prevailing policies in Australian mental health encourage the adoption of a client-centred recovery concept to counter the predominant medical model (Perron, Fluet & Holmes 2005; Stark, Stronach & Warne 2002). By way of contrast, the recovery approach sees cure as a process rather than an end-point with a focus on wellbeing, empowerment, and the development of opportunities and meaning in the lives of people with mental illness. It respects a person as being an expert in his or her own experience of mental illness with health professionals acting as facilitators to assist individuals to achieve subjective wellbeing and social engagement (Anthony 1993).

While reform of mental health services and the adoption of recovery-based policies reflect changes towards a consumer-oriented recovery approach

there 'remains a misshapen dissonance between policy at this macrolevel and the reality of practice' (Rickwood 2004, p. 2). Occupational therapists are thus working in services with identified problems with service reorientation. Rickwood (2004) noted that:

Service availability is not meeting population needs in many places, particularly in rural and remote areas and for some demographic groups (such as older people), and social and emotional well-being of Aboriginal peoples and Torres Strait Islanders remains a source of national shame (p.2).

The limited availability of current service provision increases the demands placed on therapists and reduces time spent with each service user. Contemporary practice environments emphasise efficiency measured in terms of key performance indicators and outcomes, which can create a dissonance with the principles of recovery-oriented interventions, which advocate a client-centred approach (Rickwood 2004). As noted by Ceramidas (2010) a survey of Australian mental health occupational therapists, found that despite the policy agenda targeting mental health services at State and National Level:

Only 37% of respondents believed that physical resources available for their service delivery were 'adequate and sufficient', and 22% reported inadequate and insufficient physical resources. Less than half (41%) of the respondents considered that they had 'adequate' 'physical resources' (p. 412).

Within the occupational therapy profession, there are debates about how a recovery approach should be integrated into practice (Gibson et al. 2011; Lal 2010; Lloyd et al. 2007; Lloyd, Waghorn & Williams 2008; Reibero 2005). These authors have noted the recovery approach should blend well with current practice, because occupational therapy should explicitly involve service users with 'treatment-resistant' symptoms and facilitate strategies which enable people to live well in the community (Pettican & Bryant 2007). While agreeing the concept of recovery is of benefit to many service

users, Lal (2010) voiced a note of caution, suggesting that recovery requires continued critical examination. While agreeing that the concept of recovery is beneficial to many service users, Lal (2010) questioned 'the implicit assumption that the recovery concept is universally applicable' (p. 82) and advocated that

The application of recovery theories, models and frameworks will need to be cautiously carried out in the context of populations that have traditionally been underserved by the mental health care system, including seniors, visible minorities, children and youth, recent immigrants, and refugees. It will be important to explore the meaning and process of recovery cross-culturally, across the lifespan, and at different levels of service delivery from the perspectives of potential and existing mental service recipients, caregivers, service providers, and other stakeholders. There is also a need to consider how recovery relates to other theoretical concepts, such as resilience and coping (p. 88).

In Australia, where policy advocates the implementation of the recovery approach, occupational therapists in mental health workplaces are likely to experience tensions because of the need to balance the implementation of this approach with the existing biomedical model (Lloyd, Waghorn & Williams 2008). The tension of living with these disparate models creates challenges, which are likely to impact on practitioners' choices of theoretical knowledge within existing practice settings.

Occupational Therapy Mental Health Practice

Internationally, occupational therapists have worked with people living with mental illness from the start of the profession in the USA in 1917, (Sedgewick, Cockburn & Trentham 2007). Since this time, occupational therapy has developed and practitioners work with people of all ages who live with mental health issues, in all sectors of health and social care (Brintnell et al. 2005). In Australia it is estimated 8% of occupational therapists work in mental health practice (Australian Institute of Health

and Welfare 2001). The figure of 8% was based on a 1998 survey of the workforce, with more recent reports not differentiating between specialities (Australian Institute of Health and Welfare 2006; Ceramidas 2010). National figures may become available after compulsory National Registration in mid 2012.

In Australia, the most recent analysis of mental health occupational therapy practice was conducted by Ceramidas (2010). The analysis was based on an Australian dataset from an earlier international study of occupational therapy mental health practice in eight countries (Ceramidas et al. 2009). The Australian dataset included responses from 211 occupational therapists in mental health practice, although only 21 came from NSW (Ceramidas et al. 2009). This study produced a snapshot of those in the Australian occupational therapy mental health workforce who were members of a professional organisation. As noted by Ceramidas, Forn de Zita et al., a limitation of this dataset was not all Australian occupational therapists are members of their professional organisations. The analysis of the dataset demonstrated that practitioners work with people across the life span in a range of services catering for people with mental health issues, with the majority of Australian occupational therapists working with adults (80.9%). The study also confirmed that occupational therapists work in a variety of contexts, with the majority (61.3%) working in community settings.

Table 4.1: Australian occupational therapists mental health practice (Ceramidas, 2010)

Occupational therapy service recipients according to age groupings	% of participants
Adults	80.9
Older people	28.4
Adolescents	23.0
Children	9.3
Occupational therapy service recipients according to type of organisation	% of participants
State services	65.2
Community	61.3
Community services	29.5
In-patient, short term	28.9
Out-patient	22.5
Private sector	17.6
In-patient, long term	15.7
Other	11.3
Private organisation	10.3
Federal/National health services	7.6
Professional support structure	% of participants
Multi-disciplinary team	85.4
Other occupational therapy colleagues	41.7
Occupational therapy assistant and/or Allied Health Assistant	20.9
Other	15.0
Sole practitioner	14.6

Additionally, in the Australian occupational therapy mental health workforce there are recognised recruitment and retention issues and a lack of career longevity (Hayes et al. 2008; Scanlon et al. 2010). Ceramidas (2010) noted the majority of practitioners in clinical positions were under the age of 30 years – and represented 36% of the sample. A lack of career longevity was indicated by only 46% of the respondents at age 50 years remaining within mental health settings. These Australian findings are comparable to

those from the UK, where similar retention issues apply (Duffy & Nolan 2005).

These recruitment and retention issues within the occupational therapy mental health workforce reduce the number of experienced staff available to act as mentors and supervisors for graduates. It also reduces the number of experienced practice educators who can additionally provide mental health experiences for students (Rodger et al. 2009). This is problematic because positive experiences during practice education assist in the recruitment of graduates. While some previous studies have explored the experiences of newly graduated practitioners (Lloyd, King & Ryan 2007), it may be equally important to understand what positively influences experienced mental health occupational therapists to remain in this speciality.

The Australian mental health occupational therapy workforce has been extensively researched by Lloyd, an occupational therapy researcher based in Queensland, Australia, and her colleagues (Lloyd, Bassett & King 2002; Lloyd & King 2004; Lloyd, King & Bassett 2002; Lloyd, King & McKenna 2004a; Lloyd, King & McKenna 2004b). Most of these studies employed survey research methodology to identify the practices and challenges facing Australian occupational therapists. These studies identified a loss of professional identity is associated with the imbalance of generic and specialist roles in workplaces (Lloyd, King & McKenna 2004). Despite an anticipation that practitioners would prefer specialist work, they found occupational therapists equally favoured generic and specialist work (Lloyd, McKenna & King 2004). The findings of Australian research into the difficulties of balancing generic and discipline-specific activities, and its impact on professional identity, correspond to international studies (Craig, Chacksfield & Richards 1998; Duffy & Nolan 2005; Lloyd, King & Bassett 2002). Table 4.2 summarises the generic skills identified in these three international studies of occupational therapy mental health practice.

Table 4.2: Summary of generic skills identified in three international studies of occupational therapy mental health practice

UK (Craig, Chacksfield and Richard 1998)	Australia (Lloyd, King & Bassett 2002)	UK inpatient units (Duffy & Nolan 2005)
Escorting, transport, benefits, assisting other staff	Home visits	Communication skills to interact with clients
Counselling, psychotherapy, family work	Support family and caregivers	Multidisciplinary team
Medication, blood results, testing urine	Advocacy for clients	Flexibility and adaptability
Management	Visiting clients in hospital	Assessment
Duty, on call, emergency	Arranging appointments with doctors	Group work
Keyworker, coordination	Supportive counselling	Patience, empathy, and a sense of humour
General assessments	Intake and triage	
Secretarial	Mental state examinations	
Control and restraint	Crisis intervention	
Organising social events	Arranging accommodation	
Miscellaneous	Family psycho-education	
	Medication education	
	Help with finances	
	Arranging hospital admission	
	Attending case presentations and reviews	
(Craig, Chacksfield & Richards 1998; Duffy & Nolan 2005; Lloyd, King & Bassett 2002)		

Table 4.3 Summary of discipline-specific skills identified in three international studies of occupational therapists in mental health practice

UK (Craik, Chacksfield and Richard 1998)	Australia (Lloyd, King & Bassett 2002)	UK inpatient units (Duffy & Nolan 2005)
Creative activities	Activity analysis	Activity analysis
Leisure	Assessing occupational performance	Assessment and treatment with an emphasis on activity
ADL	Functional assessments	Grading of activity.
Social skills	Activities of daily living interventions	Functional skills
Assertiveness	Occupational analysis and lifestyle redesign	Developing independence
Work	Planning and using activities	Using activity to structure time
Anxiety management	Community living skills training	Using occupational performance in the workplace
Counselling	Community orientation/access with clients	
(Craik, Chacksfield & Richards 1998; Duffy & Nolan 2005; Lloyd, King & Bassett 2002)		

These research studies into the roles and practical actions of occupational therapists demonstrate the range and diversity of interventions undertaken by occupational therapists in mental health, and the differences in language used to explain them within these research papers. Craik, Chacksfield and Richards (1998) suggested that the diversity of intervention and opportunity for autonomy and creativity of practice, initially attracts occupational therapists to work in mental health practice. Nevertheless, over time, the individualised, nature of practice interventions contributes to the frustrations experienced by occupational therapists (Fortune & Fitzgerald 2009; Smith & Mackenzie 2011). These different interventions confuse colleagues and lead to frequent questioning about the occupational therapy role, choice of intervention, and underpinning theories. The conclusions of these authors mirrored the earlier findings of a US survey by

Barris and Kielhofner (1985) where respondents named deficiencies in role definition, a lack of a unifying theory, and a lack of research validating the profession as major problems for occupational therapists in mental health practice. Fortune (2000) noted a lack of role clarity led occupational therapists to deviate from occupation-based practice. It is thus important to understand how these frustrations impact on practitioners' use of theoretical knowledge, and how the ability to articulate the theoretical underpinnings of interventions to others might impact on practice. This is the focus of the following section.

Competing Discourses in Mental Health Practice

In Australian mental health practice, occupational therapists are expected to draw on various sources of propositional knowledge, each with competing assumptions. These are: an occupational perspective (Farhall et al. 2007); psychological theories (Finlay 2004); the medical model (Nye 2003) and the recovery approach (Anthony 1993; Deegan 1996; Rickwood 2004). However, little has been done to investigate how these competing perspectives impact on an individual's practice, or how their professional paradigm is influenced by their personal values, theories, and experiences.

The previously discussed policies, which influence Australian mental health services, increase the expectations on mental health occupational therapists to draw upon generic and discipline-based knowledge (Lloyd, King & McKenna 2004b). The generic knowledge required for mental health practice and for case management is largely based upon a foundational knowledge of medical conditions and their treatment by medication, and of the NSW Mental Health Act (NSWHealth 2007). Within environments strongly focused on the biomedical aspects of illness, mental health practitioners are expected to know the diagnostic categories for mental health disorders as stated in the 'Diagnostic and Statistical Manual

of Mental Disorders' [DSM-IV-TR] (American Psychological Association, 2000) and to be knowledgeable about prescribed medications and recommended treatments. This formal generic medical knowledge is included within occupational therapy education.

In addition, the discourse of evidence-based practice is also likely to influence practitioners' knowledge choices. In the last decade, the need to establish evidenced-based practice knowledge has become increasingly important in all areas of health and social care. Consequently, the concept of evidence-based medicine affects all health and social disciplines workers. The ability to articulate the theoretical and factual knowledge underpinning practice is vital in health and social care settings, where practitioners are increasingly required to account for and justify their treatment interventions, report on outcomes and cite the research supporting specific interventions or to seek knowledge to create these links. In turn, an inability to articulate what underpins practice can negatively influence the commissioning of services, staffing levels, and maintenance of professional identity. Therefore, in mental health practice, as in other sectors of health and social care, occupational therapists are influenced by the increased pressure to adopt evidence-based practice (Lloyd, Bassett & King 2004). Furthermore, evidence-based practice is likely to be another determinant of choice of theoretical knowledge and a contributing factor to occupational therapists' attraction to the use of psychological theories, rather than occupation-focused models, to direct practical actions. In mental health practice, Sheldon (2000) suggested that while there is evidence for the efficacy of psychological frames of reference and their associated therapies, the evidence for behavioural and cognitive-behavioural therapies is often based on specific problems in settings far removed from the more complex reality of the health and social care settings (Sheldon 2000). These research settings do not tend to reflect the complex reality of occupational therapy interventions involving

interactions between the person, their environment, and their occupations (Law et al. 1996).

Australian studies into occupational therapists' use of evidence-based practice demonstrate that while practitioners value the idea they find it difficult to access and integrate researched evidence into their practice (Bennett et al. 2003). Thus, the choice of psychological theories may be compounded by a perceived lack of evidence for occupational therapy practice in general (Bennett et al. 2003) and specifically in mental health (Pettican & Bryant 2007). The nature of individualised tailor-made programs may contribute to the reported lack of evidence-based mental health practice (Lloyd, Bassett & King 2004; Paul 1996). This evidence of practice is possibly harder to capture than that of psychology, where the use of standardised, repeatable programs make it easier to gather quantifiable outcome data to support practice and professional identity.

The dominance of psychological theories in the evidence-based practice discourse is demonstrated by the use of the cognitive behavioural approach by occupational therapists. The World Federation of Occupational Therapy's survey of mental health practice in eight member countries (Brintnell et al. 2005), found the use of cognitive-behavioural therapy (CBT) (Beck 1976) was widespread. The question on CBT was included in the study because according to the researchers: It 'has fast become the preferred first line approach in mental health care in most of the officially participating countries' (Brintell et al. 2005, p.10). Its purported dominance is emphasised because there were no questions about the use of other approaches or occupation-focused models in the study's survey.

In Australia, Caramidas (2010) reported widespread adoption of cognitive-behavioural approaches by Australian mental health occupational therapists, with 76% using these in treatment interventions. This compared to 45% of those surveyed by Bartlow and Hartwig (1989). This result

showed growth in the use of this psychological frame of reference and its associated therapies over 20 years. The causes for this growth need further investigation as Australian occupational therapists are likely to be influenced by the dominance of CBT in practice. The dominance of psychological therapies over occupation-based practice initiatives is demonstrated in the Australian Federal Government's Medicare Benefits Schedule (Better Access). The Better Access Program was developed to help service users understand more about mental illness and to learn strategies to manage the difficulties experienced. This scheme provides a service user with up to ten sessions with an appropriately trained doctor, social worker, or occupational therapist (Commonwealth Department of Health and Ageing 2011). However, within the scheme the term 'psychological intervention' is recommended as the nature of the interventions to be provided to service users. This focus has resulted in the Australian Psychological Society, in conjunction with the Australian Association of Social Workers (AASW) and Occupational Therapy Australia (OTA), making a training module in cognitive-behavioural therapy available online to meet this need. In reinforcing CBT's dominance within mental health, Better Access implies an occupational therapist's paradigm-dependent practice is not sufficient to meet Better Access service-users' needs.

The dominance of psychological frames of reference and psychotherapies in mental health relate partly to the changing face of healthcare, when evidence-based practice is highly regarded by policy makers and managers. Consequently, a perceived relative lack of empirical data regarding the efficacy of occupation-based interventions compared to psychologically-based intervention is problematic (Bennett et al. 2003). This may be one reason for the reduction in occupation-based practice in mental health. However, the increased adoption of psychological therapies may be one of

the contributing factors to role blurring and negative impacts on professional identity for occupational therapists.

In turn, it can be argued professional identity is linked to use of occupation-focused models and frames of reference because they inform professional reasoning and provide an understanding of people, situations, and events. Fortune (2000) argued some of the difficulties associated with the maintenance of occupational therapists' professional identity in mental health practice, and a tendency to 'fill in gaps', may be associated with practitioners not using the contemporary occupational paradigm and philosophy. Others have concluded that the teaching of occupation-focused models and their use in practice could reorientate mental health occupational therapists towards occupation-based practice (Bartlow & Hartwig 1989; Haglund et al. 2000). However, even though occupation-focused models are now integrated in occupational therapy entry-level programs, there is no evidence which identifies how curricula impact on their use in practice (Ashby & Chandler 2010). As described in Chapter 2, it is thus important to further explore how competing discourses are likely to influence what Habermas (1972) referred to as social norms, and emancipatory or liberating knowledge.

Tensions in Interprofessional Teamwork

The shift in Australian mental health towards community-based practice has increased the expectation on health and social care professionals to work outside their professional domain in interprofessional teams (Meadows, Singh & Grigg 2007). Investigations into teamwork show, while working in teams is thought to have potential benefits for service users, it is often a source of tension for those working within them (Nolan & Hewison 2008; Rosen & Callaly 2005; Xyrichis & Ream 2008). The causes of these

tensions vary and include the blurring of professional roles and a lack of leadership.

The move to community-based mental health services and the subsequent involvement of occupational therapists in interprofessional teams has presented practitioners with a number of challenges. In Australia, occupational therapists who work in community mental health teams have reported how this has led to professional identity problems (Lloyd & King 2004; Lloyd, King & McKenna 2004b). Working within these teams places pressure on occupational therapists because the need to balance generic case management invariably restricts the time allocated for discipline-specific interventions.

One source of concern for health and social care professionals involved in community-based interprofessional mental health teams is the notion of 'creeping genericism' (Brown, Crawford & Darongkamas 2000) and role blurring. Molyneux (2001) found generic posts led to further demarcation of roles, which encourage boundaries rather than erode them. More positively, these studies found some practitioners regarded the opportunity to work in teams as a liberating experience because of the opportunity to learn from others. The danger is in the potential to lose one's professional identity due to this role blurring.

Professional Isolation

Further challenges arise in mental health practice when occupational therapists are located in interprofessional, or multidisciplinary teams where they are in the minority (Scanlon et al. 2010). This means having to contend with the tensions created by differing discourses. The majority of studies conclude working in a multidisciplinary team may erode a sense of professional identity. This situation is worse for those from occupational therapy and social work who are often minority professions. Professionals

working in these situations can experience a sense of isolation and may be deprived of a sense of support, and professional identity, from others of a similar background (Scanlon et al. 2010). This is problematic because early work on multidisciplinary teams identified professional identity was important and desirable to survive the knockabout environment multidisciplinary could create (Payne 1982).

The professional isolation experienced as a minority team member is exacerbated if clinical supervision is conducted by a colleague from a discipline, who may not understand, or share an occupational perspective (Scanlon et al. 2010). Ceramidas (2010) reported that only 25% of Australian mental health occupational therapists have support from other occupational therapists within their teams, and locating supervisors from within the profession is problematic. A lack of supervision, or supervision provided by someone external to the profession, reduces the opportunity to learn from others' use of occupation-focused models, or to reflect upon practical actions from a professional identity perspective.

Communication

Teamwork is enhanced by clear communication with colleagues (Molyneux 2001). This is particularly challenging for occupational therapists in mental health practice due to difficulty in explaining the professional reasoning which underpins interventions. This problem may add to the negative experiences of working within mental health teams (Fortune & Fitzgerald 2009).

Research studies and opinion papers have identified the cause of the difficulty in explaining and articulating rationales for the use of occupation as a therapeutic medium to achieve occupation-oriented goals (Eklund 2002; Fortune & Fitzgerald 2009; Kinn & Aas 2009). Eklund (2002) suggested that difficulties in articulating the explicit and implicit outcomes

of occupational therapy interventions relate to the focus on occupational performance in current occupation-focused models, such as the CMOPE and MOHO. Eklund argued that this limits a practitioner's ability to describe the wider use of occupation as a therapeutic medium to achieve subjective wellbeing for service users.

Fortune and Fitzgerald (2009) proposed a solution to these difficulties is for mental health occupational therapists to develop the ability to articulate their contribution to the team and how they use occupation as a means and end of treatment. They argue that the ability to articulate what underpins practice is connected to professional identity and occupational paradigms. However, Kinn and Aas (2009) found that even when an occupational therapist has a strong professional identity and occupational role, he or she may still experience difficulties in describing the use of occupation in practice. These findings suggest that the connection and use of the occupational paradigm is significant in communicating what underpins practical actions. Practitioners who find it difficult to explain the implicit and explicit goals of occupation-based intervention in mental health practice, or who seek greater validation of their professional status and roles, may select generic theories, which are more readily understood and valued by other professionals, often from psychology or psychiatry discourses, which are perceived as more powerful.

Case Management and Generic Working

The adoption of case management models of service delivery in Australian mental health practice, and other practice areas, has created competing demands for occupational therapists (Lloyd, King & McKenna 2004b). The process of case management cuts across professional affiliations to place the service user in the community as the focus. The case management role includes generic tasks, which include intake and assessment, symptom monitoring and crisis management (Meadows, Singh & Grigg 2007). It

requires case managers to retain responsibility for a service-user's safety within the community while also performing discipline-specific roles. Occupational therapists who work in mental health use theory from a range of sources to structure their interventions. This is particularly true of occupational therapists who work as case managers in community mental health teams (Harrison 2005b; Harrison 2005c).

The increase in case management models is one of the driving forces determining the need for generic knowledge in mental health practice. Employment as a case manager requires a health or social care professional to seek generic professional knowledge drawn from a medical model which assumes 'social and individual pathologies are expressed symptomatically and can be diagnosed and cured according to an organic conception of health and disease' (Nye 2003, p. 115).

For occupational therapists, the adoption of case management models of service delivery creates competing demands and difficulties balancing generic and discipline-specific work (Lloyd, King & Ryan 2007; Lloyd, McKenna & King 2004). This places considerable pressure on Australian occupational therapists who perform and balance the two important roles of case manager and occupational therapist (Lloyd, King & McKenna 2004a; Lloyd, King & McKenna 2004b; Lloyd, McKenna & King 2005). The UK literature also reflects these issues (Harries 1998; Hughes 2001b; Parker 2001). Case management roles require the practitioner to take charge of all aspects of a service-user's recovery: the duties include completion of generic assessments of risk, monitoring of medication compliance, monitoring of symptoms, referral to other agencies, housing, and financial services (Lloyd, King & McKenna 2004a). While it is possible to refer to other disciplines, this role requires occupational therapists to have generic mental health knowledge, and the adoption of a biomedical rather than a biopsychosocial approach. The majority of studies into the role of occupational therapists in community mental health teams show

practitioners experience these tensions negatively (Harries 1998; Harries & Gilhooly 2003; Lloyd, King & Bassett 2002; Parker 2001). The main issues for occupational therapists stem from the reduced time available for discipline-specific tasks, which results in reduced job satisfaction (Ceramidas et al. 2009).

In contrast, Harrison (2003) argued generic work in the UK offers occupational therapists professional opportunities which expand the validation of professional skills by others. However, the need for validation by others can lead to occupational therapists 'filling in gaps' (Fortune 2000). This gap filling involves occupational therapists performing counselling and anxiety management, which psychologists may consider to be outside the occupational therapy professional domain.

Fortune (2000) discussed the relationship between occupational therapists' role identity and professional thought and action based on a study of empirical data of the roles adopted, and the guiding philosophies enacted by four occupational therapists working in child and adolescent mental health settings. She posited that a failure to ground practice in occupational philosophies contributes to perpetuating an incoherent role identity. She further argued the adoption of an occupational paradigm in practice could 'liberate occupational therapists from role incoherence' (p. 225), and enable them to reclaim their identity as therapists of occupation. However, as noted in Chapter 2, elements of occupational philosophies may contain assumptions that require further critical analysis (Hammell 2009a).

Perceived Lack of Respect

Health and social care professionals in interprofessional teams, often express that colleagues from other disciplines do not fully appreciate their role and professional knowledge (Larkin & Callaghan 2005; Xyrichis & Lowton 2008). Larkin and Callaghan's (2005) study of mental health teams

in East London in the UK concluded that, while the majority of professionals were clear about their roles, they perceived other members of the team did not recognise or understand these roles. They concluded this was likely to be worse for those from minority professions, such as occupational therapy and social work. Research studies into occupational therapists' work in mental health teams have consistently reported practitioners' frustrations with a perceived lack of respect from other disciplines for their occupational perspective and occupation-based practice (Hayes et al. 2008; Rodger et al. 2009; Scanlon et al. 2010). Such research outlines mental health occupational therapists' insecurities about professional roles and identities. These studies, and others which research how others view their profession and roles (Smith & Mackenzie 2011), provide an external viewpoint of how the profession and its practice is perceived by others.

Ceramidas (2009) suggested that mental health occupational therapists experience tensions because, while they are process-driven, they work with nurses who they perceive use a task-oriented approach. Confusion is also likely to stem from differences between biomedical and occupational perspectives (Lloyd, King & Ryan 2007). Mullen (2009), Cutcliffe and Happell (2009) identified that nursing staff may focus on the biomedical aspects of their professional models rather than biopsychosocial issues. This is most apparent in inpatient units where nurses play a custodial and governing role rather than a caring or rehabilitative role (Mullen 2009). This issue was explored by Clinton and Hazleton (2002) who used Foucault's concepts of dominant discourses and governmentality to explain this tension in Australian mental health services.

The cumulative effect of tensions caused by dominant discourses in the mental health workplace can result in difficulty in retaining occupational therapy staff. Living with these tensions requires an exploration of occupational therapists' professional resilience. This is timely given that the

quality of professional resilience enables practitioners 'to bounce back from adversity, persevere through difficult times, and return to a state of internal equilibrium or a state of healthy being' (Edward 2005, p. 142). This quality arises from professional self-care and is thought to be essential for practitioners who work in the health and human services industry (Fink-Samnick 2009). Despite the identified challenges facing occupational therapists in interprofessional team work and other challenges in mental health practice (Lloyd, King & Ryan 2007; Reeves & Summerfield Mann 2004; Rosen & Callaly 2005; Stark, Stronach & Warne 2002) this issue had not been discussed in the occupational therapy literature prior to the current study. However, it had been explored in relation to nursing where it is defined as professional self-care involving practitioners adoption of strategies to reduce vulnerability, and assist in the response to occupational stressors and life challenges, while maintaining the professional values, which ensure career sustainability (McGee 2006).

Conclusion

While Australian mental health practice creates particular challenges for occupational therapists, the literature in Chapter 4 demonstrated there are common challenges internationally. In occupational therapy, these pressures connect to how a practitioner negotiates ways of living with the tensions created by different discourses. The research into the challenges of teamwork in mental health has developed and contributed to understandings of the factors affecting all health and social care professionals. The intention of this thesis is to build on previous knowledge and stimulate some insights into the experiences faced by minority professions in multidisciplinary teams and the pressures faced by all health and social care professionals in contemporary mental health practice.

The literature provides interesting insights into the complexity faced by occupational therapists practising within different discourses and the potential creation of professional dissonance and resultant challenges found in daily practice. Research studies have explored the work of mental health occupational therapists from different perspectives seeking to understand challenges to professional identity (Fortune & Fitzgerald 2009; Harries & Gilhooly 2003; Lloyd, King & McKenna 2004b). These studies highlighted the importance of practitioners' ability to articulate what underpins their mental health practice. They offered insight into the nexus between the practitioners' environment and their professional identity and how these determine the knowledge used and valued, and practitioners' subsequent practical actions. However, these studies into occupational therapists working in mental health practice did not include in-depth explorations of theoretical knowledge.

In occupational therapy research, qualitative methodologies are more suited to unravel what Creek (2003) described as 'the complexity of practice' (Eklund & Leufstadius 2007; Gunnarsson & Eklund 2009). To determine a practitioner's use of theoretical knowledge requires an exploration of the different theories (explanations) used to judge a service-user's occupational issues (Trevithick 2008a). It requires reflection on how this theoretical knowledge determines practical actions and how these competing discourses impact upon practitioners' choices. In mental health practice, theoretical knowledge illuminates the understanding of a person's occupational issues, their roles and responsibilities in relation to those issues, and the practice approaches, perspectives, skills, and interventions needed to address the problems presented (Finlay 2004).

The intention of this study to identify whether the use of valued theoretical knowledge is a 'protective factor' which supports experienced mental health occupational therapists to remain in the workforce. In this thesis, I argue an occupational therapist's choice and application of theoretical

Chapter 4: Influences on Occupational Therapy Practice in Mental Health

knowledge in mental health practice may be viewed through an examination of the discourses, which influence clinical interactions. This insight guided the research design and methodology and provided a lens through which to interpret the findings from the research which are presented and discussed in Chapters 6 and 7. The following methodology chapter describes the research aims, data collection methods and the analysis process, which were determined in light of the findings from the literature review in Chapters 2, 3, and 4.

CHAPTER 5: METHODOLOGY

This chapter provides an overview of the research strategy. It begins with an outline of the purpose of the study and the research questions. I establish the rationale for, and explanation of, the research design, the research methodology, and how these strategies were used to explore the valuing and use of different forms of theoretical knowledge by occupational therapists working in mental health practice in a regional area of NSW, Australia. I then provide a detailed description of the research procedures, including: the methods used to gather the data and explain the processes used to interpret it, and the theoretical frameworks, which influenced its analysis and interpretation. I have written this chapter in the first person to make my reasoning explicit, and make my stance and decision-making processes transparent.

Purpose of the Study

As identified in the literature review, there is limited research worldwide about the different forms of theoretical knowledge used by occupational therapists in mental health practice. The purpose of this research was to develop a deeper understanding of the ways in which occupational therapists in mental health practice value and use different forms of theoretical knowledge to inform their practical actions.

Consequently, a key component in this research was to understand how practitioners' use of different forms of theoretical knowledge progresses throughout their careers and what influences its use and its ascribed value. This included ways of unearthing and exploring those aspects of use which

had become tacit. This was necessary because as practitioners develop their experience in clinical work, aspects of their practice becomes tacitly embedded in daily practice and it becomes increasingly difficult to articulate practice to others and requires methods to disclose this (Higgs & Titchen 2001).

Research Questions

To gain an understanding of these issues, my research began with broad research questions intended to explore the multifaceted ways in which occupational therapists in one regional public health service in NSW, Australia, used different forms of theoretical knowledge to promote practical actions in mental health practice. I asked:

1. How and why do occupational therapists value theoretical knowledge in mental health practice?
2. How do occupational therapists in mental health practice use occupation-focused models of practice?
3. How do occupational therapists use psychological frames of reference derived from psychological theories?
4. How do social environments, such as practice contexts and communities of practice, shape the different forms of theoretical knowledge valued and used in practice?
5. What is the nature of the relationship between a practitioner's use of different forms of theoretical knowledge, their personal paradigm and practical actions?
6. How does theoretical knowledge evolve and potentially inform the practical actions of experienced occupational therapy mental health practitioners?

Using Qualitative Methodology

I chose to employ a qualitative research methodology, grounded in the interpretivist-constructivist paradigm because I believed it was most likely to provide answers to the research questions outlined above, and to develop my understanding of how occupational therapists valued and used knowledge in practice. Qualitative methodology enables the exploration of topics where little information or evidence exists (Denzin & Lincoln 2005). As identified in the literature review, while other professions have described and explored how theoretical knowledge informs practice, within occupational therapy little is known about this aspect of practice.

The use of a qualitative methodology acknowledges that each occupational therapist who became part of the study had his or her own dynamic and negotiated reality, which was affected by his or her personal experiences and practice contexts (Minichiello & Kottler 2010). This acknowledgement is important as much of the previous research on the use of theoretical knowledge in occupational therapy, and particularly mental health practice, has used surveys to gather data. While these surveys provided a broad snapshot of occupational therapists' use of theoretical knowledge (Haglund et al 2000), they did not lead to in-depth understanding of this. Thus, it is unlikely that surveys, or quantitative methodologies would be able to unravel the complexity of practitioners' use of theoretical knowledge because they do not go deep enough into the topic, nor do they provide opportunities for reflection (Osmond 2005; Osmond & O'Connor 2004; Trevithick 2008a).

Adopting an Interpretivist-Constructivist Research Approach

In this research, I used an interpretivist-constructivist research paradigm. According to Denzin and Lincoln (2005), a paradigm is the net containing

the researcher's epistemological, ontological, and methodological premises. The interpretivist-constructivist paradigm sees knowledge as socially constructed and influenced by people's worldview (Guba & Lincoln 1984). Hence it sees the choices people make as being value laden and context bound. The use of this qualitative interpretivist methodology allowed full exploration of my research questions and aimed to analyse how the social worlds and the meanings of events influenced the value practitioners placed on the theoretical knowledge they used (Higgs et al. 2007). The use of an interpretivist approach explored the multiple influences which shaped the theoretical knowledge participants used and valued in their complex clinical interactions.

In terms of an interpretivist-constructivist approach, the object of exploration is the individual's subjective understanding of his or her world – his or her lived experience. This understanding is socially constructed and situation specific and is influenced by his or her environments. Schwandt (1994) noted that interpretivism, and constructivism are theoretical frameworks 'that steer researchers towards a particular outlook' (p. 130). Both seek to understand the complex world of 'lived experience' from the point of view of those who live it. Thus, knowledge is highly subjective and relative and, rather than having one truth, each participant in this study would have a particular understanding of what constituted professional knowledge for practice based on his or her lived experience as an occupational therapist in mental health. As discussed in Chapter 2, Björklund (1994) and Törnebohm's (1991) work is particularly relevant to this concept. They claim each occupational therapist is influenced by his or her professionally-shaped knowledge and by his or her socially constructed worldview. Thus, a key aim of this study was to explore the diverse influences on practitioners' choices, values, and the theoretical knowledge informing their practice.

The constructivist approach led my inquiry to focus on the practitioners' understanding of theoretical knowledge in the context of their professional journeys in mental health settings. Importantly, while interpretivism and constructivism assume each participant's worldview will influence his or her use of knowledge in practice, there is a strong likelihood people will use similar knowledge because of the professionalisation process and the way the practice setting shapes particular forms of practice. Within this study, these shared elements were likely to reflect similar environments shaping practice at the macro (policy), meso (organisational), and micro (individual) levels (Bronfenbrenner 1979). In addition, the homogeneity of the group was strengthened by their shared professional qualifications, interest and experiences in mental health practice.

Narrative Inquiry

After a review of the literature from other disciplines, narrative inquiry methodology was chosen as the most effective way to capture the similarities and differences between practitioners' value and use of different forms of theoretical knowledge within the specialised area of mental health. This methodology is in keeping with an interpretivist-constructivist qualitative methodology and allowed an exploration of practitioners' constructed storied accounts of their professional lives (Holloway & Freshwater 2007) by listening to participants' professional histories, and case-based examples and exploring the similarities and differences within the specialised area of mental health.

This approach to gathering information about professional histories was supported by Wengraf (2001). I designed the research by building on the experiences of those researchers who had shown how narrative inquiry could be used to elicit an understanding of the theoretical knowledge used by nurses (Holloway & Freshwater 2007), social workers (Nygren & Blom 2001), and teachers (Clandinin & Connelly 2000; Eraut 1994; Eraut 2007). In

these studies, narrative inquiry had allowed the researchers to represent how the unique experiences of practitioners shaped their use of theoretical knowledge in practice and were influenced by differing career experiences (Reissman 2008). This is because narrative inquiry is based on social-constructivism, which stresses the world we experience arises from multiple, socially constructed realities, which shape how individuals make sense of their experiences. According to Guba and Lincoln (1984), although these realities are very often shared, this 'does not make them more real but simply more commonly assented to' (p. 89).

Narrative interviewing is consistent with an interpretivist-constructivist approach (Kvale 1996). Thus, for this research, with its focus on the evolution of practitioners' value and use of different forms of theoretical knowledge, it was important to ask participants to situate this evolution within their professional histories. It was also important the interviewing style could reveal the tacit dimensions of the participants' practice. Eraut's (1994, 2007) research into knowledge use in teaching and nursing showed tacit knowledge could be revealed by asking participants to describe their professional histories, and by citing individual case stories from their professional practice. Previous studies, and my own experiences in conducting workshops, had demonstrated direct questioning of practitioners about their use of theoretical knowledge was unlikely to uncover the complexity of its use in practice, or reveal the 'tacit dimension'. My professional experiences in conducting workshops for clinicians on the use of theoretical knowledge had shown the most effective ways of eliciting practitioners' descriptions was to explore this in the form of case-based stories (Ashby 2000; Ashby 2011a).

Reflexivity

Reflexivity refers to a type of understanding gained through reflecting on the way in which our particular social positioning influences our values,

beliefs, and assumptions (Hsiung 2008, p. 212). The reflexive consideration of my role as researcher led me to reflect upon the power dynamics between researcher and participant. There was a co-constructed element to this research as my interactions with the participants were informed by my own ideas and clinical experiences as an occupational therapist in mental health practice. These ideas and experiences had shaped my professional identity, which was likely to be similar to the experiences of those I would interview. As an educator and researcher it was important to ensure participants knew their opinions would be respected in each interview. Thus, I began each interview by assuring participants I was interested in their stories about their use of theoretical knowledge in practice and no judgments would be made about the validity of their knowledge choices. I emphasised the central aim in this study was to obtain and analyse their opinions. I considered this reassurance important to ensure practitioners did not change their responses to ones they thought I wanted to hear, in response to my role as an academic, and presenter of theory-based workshops. Some participants asked for my opinions about a certain action or use of theoretical knowledge. When this occurred, I tried to limit my response but, because of the conversational nature of the semi-structured interviews, my answers also aimed to build the participants' confidence in describing their use of theoretical knowledge in practice, and redress the power balance issues.

Research Process

The stages of the research process followed in this study are shown below in Table 5.1.

Table 5.1: Stages in the PhD research process

Stage*	Activity	Purpose
Stage 1: Literature review	A review of the literature was undertaken relating to: Theoretical knowledge and occupational therapy in mental health practice.	Analysis of the theoretical context of the study, prior research, and contemporary knowledge on occupational therapy in mental health practice (see Chapters 2 and 3).
Stage 2: Ethics clearance	Ethics proposal.	Approved by HNEHealth, (Approval no. H-2008-0381) and University of Newcastle (H-2008-0381).
Stage 3: Recruitment	Sample selection. Sample recruitment.	Recruitment
Stage 4: Data collection	Research diary. In-depth interviews: Phase 4.1: In-depth interview 1 and member checking. Phase 4.2: In-depth interview 2 and member checking.	Reflexive analysis. Narrative inquiry: Exploration of practitioners' journeys.
Stage 5: Data analysis	First cycle of coding: Pre-reading Reading and cross-sectional coding of transcripts Second cycle coding: Analysis of themes: Narrative thematic analysis Adding and coding new data Rewriting: Cross-analysis of themes Interpretation and reporting of findings	Interpretation
Stage 6	The dissemination of findings through submission of articles to refereed journals, and conference presentations. Writing of the thesis.	Dissemination
	* Some stages were conducted concurrently	

Stage 1: Literature Review

A review of the literature was undertaken relating to theoretical knowledge and occupational therapy in mental health practice.

Stage 2: Ethical Issues Relating to The Study

In June 2008, prior to the commencement of this research, I was granted ethics approval from the Hunter New England Health Authority's Human Research Ethics Committee. The research was approved under the title *Practice knowledge valued by occupational therapists in mental health settings* (HNEHREC REFERENCE No: 08/06/18/5.07: NSW HREC REFERENCE No: 08/HNE/164) (see Appendix I). The research was subsequently registered with the University of Newcastle Human Research Ethics Committee (H-2008-0381).

All the data from the research remains with transcripts and other documents kept in a locked cabinet in my office. The stored data does not mention the participants' names or details and only de-identified data are presented in this thesis, in presentations, and in publications.

Stage 3: Sample Selection and Recruitment

The research was conducted within the Mental Health Service in the Hunter New England Health (HNEHealth) area in NSW, Australia. Occupational therapists who worked in mental health were selected to participate in the study because previous research indicated that they used a range of theoretical knowledge in practice (Haglund et al. 2000), and were able to make choices about the theoretical knowledge driving their practice.

I thought purposive sampling was the most appropriate tool to ensure participants were able to answer the research questions (Silverman 2000). This led to the development of the inclusion criteria for the study: i)

participants were occupational therapists employed by Hunter New England Health Area's mental health services; ii) who had more than two years' experience working in mental health practice and iii) who had worked in more than one mental health practice setting or workplace. This strategic sample was intended to answer the highly specialised research questions (see Appendix IV) and was not presumed to represent all Australian occupational therapists. The rationales for these inclusion criteria are outlined below.

- The choice to use occupational therapists working in one area's Mental Health Service was made for pragmatic and conceptual reasons: It contextualised the study in a geographical area, within an area of jurisdiction influenced by similar policies at a State, Regional, and Service level. This ensured participants would be more likely to experience similar organisational pressures than if they worked in differing health areas.
- To answer my research questions, I wanted to explore knowledge use among practitioners with experience of more than one mental health practice setting. I anticipated this would allow participants to compare and contrast the knowledge used in different settings, and the similarities or differences of influence from one workplace to another, to provide rich data for analysis.
- I chose practitioners with more than two years' experience based on findings from studies on occupational therapy graduates' preparedness for practice, which found those with less than two years' experience, in all practice settings, tended to be more focused on consolidation of their practical skills rather than on the use of theoretical knowledge (Hodgetts et al. 2007; Quick, Forsyth & Melton 2007). It was anticipated the sample would comprise a minimum of eight participants.

Chapter 5: Methodology

At the time of recruitment in December 2008, 42 occupational therapists were employed in HNEHealth's Mental Health Service. The Professional Leader in Occupational Therapy in Mental Health identified those occupational therapists who met the inclusion criteria. By application of the criteria, 18 potential participants were identified by the Professional Leader from the 42 occupational therapists employed by Hunter New England Health Area. During this process, the occupational therapists' privacy was protected as I did not have direct access to this database or employment records. The Professional Leader then provided a list of the names and contact workplace email addresses of the 18 practitioners who met the criteria for the study.

All 18 occupational therapists who met the criteria were invited to participate. To ensure participation in the study was voluntary, each therapist was emailed a copy of the Information Statement (see Appendix II). This statement invited them to participate in the study. Each potential participant had one calendar month, from the date of the emailed invitation, to consider whether to participate and to contact me if they required further information to make their decision. If there was no contact within a one-month period, no further contact was made. A condition of the ethical approval was that I was unable to ask the non-responding practitioners their reasons for not participating. However I received responses from three practitioners who were not able to participate. One noted she was due to take maternity leave during the study's timeframe, and two others commented they felt their part-time work would make participation difficult.

Following the recruitment process, ten occupational therapists confirmed participation, although one of these practitioners was forced to withdraw prior to the first interview as it coincided with a period of extended leave. Prior to data collection, active consent was sought from each participant for

all aspects of the research with each participant signing a consent form before the first interview began (see Appendix III).

Demographics of The Participants

All the participants (n=9) had graduated from two entry-level programs in NSW (see Table 5.2). Three graduated from Sydney University and six from the University of Newcastle.

Table 5.2: Description of participants' entry-level education

Pseudonym	University program	Year of graduation
Maria	Sydney	1978
Eliza	Newcastle	1993
Alex	Newcastle	1993
Sarah	Sydney	1996
Anna	UQ, Newcastle	1997
Megan	Sydney	1997
Diana	Newcastle	1998
Bronwyn	Newcastle	2000
Liam	Newcastle	2002

As noted in the inclusion criteria, at the time of the first and second interviews all the participants worked in mental health services within Hunter New England Health and only Bronwyn, changed workplaces during the research period. Their career length in mental health practice ranged from 5 to 30 years at the time of the first interview. They had worked in from 2 to 14 different mental health workplaces (see Table 5.3), with three also having experienced working in the public health system in the United Kingdom.

Table 5.3: Participants' careers in mental health

Pseudonym	Years in mental health	Number of workplaces	Current service-user group
Maria	30	3	Adults
Alex	17	4	Adults
Eliza	17	> 10	Management
Diana	14	> 10	Adults
Sarah	14	> 10	Children and Adolescents
Megan	13	> 10	Adults
Anna	11	4	Adults
Bronwyn	8	5	Children and Adolescents
Liam	5	2	Adults

Stage 4: Data Collection

Driven by the interpretivist-constructivist paradigm, a qualitative research design was used. To determine the most appropriate research design, I referred to the literature on practice knowledge, theoretical knowledge and professional reasoning in the health and social care professions. In addition, because the research explores occupational therapists' mental health practice, the review of the literature extended to an inclusion of policies and known discourses likely to shape the use of theoretical knowledge in this setting. The literature informed my research design, particularly my choice of in-depth interviews which focused on eliciting professional histories and case-based stories from practice, as the main source of data, and assisted in the development of the general research questions.

The research process comprised three phases of data collection described in Figure 5.1. Each phase is discussed below.

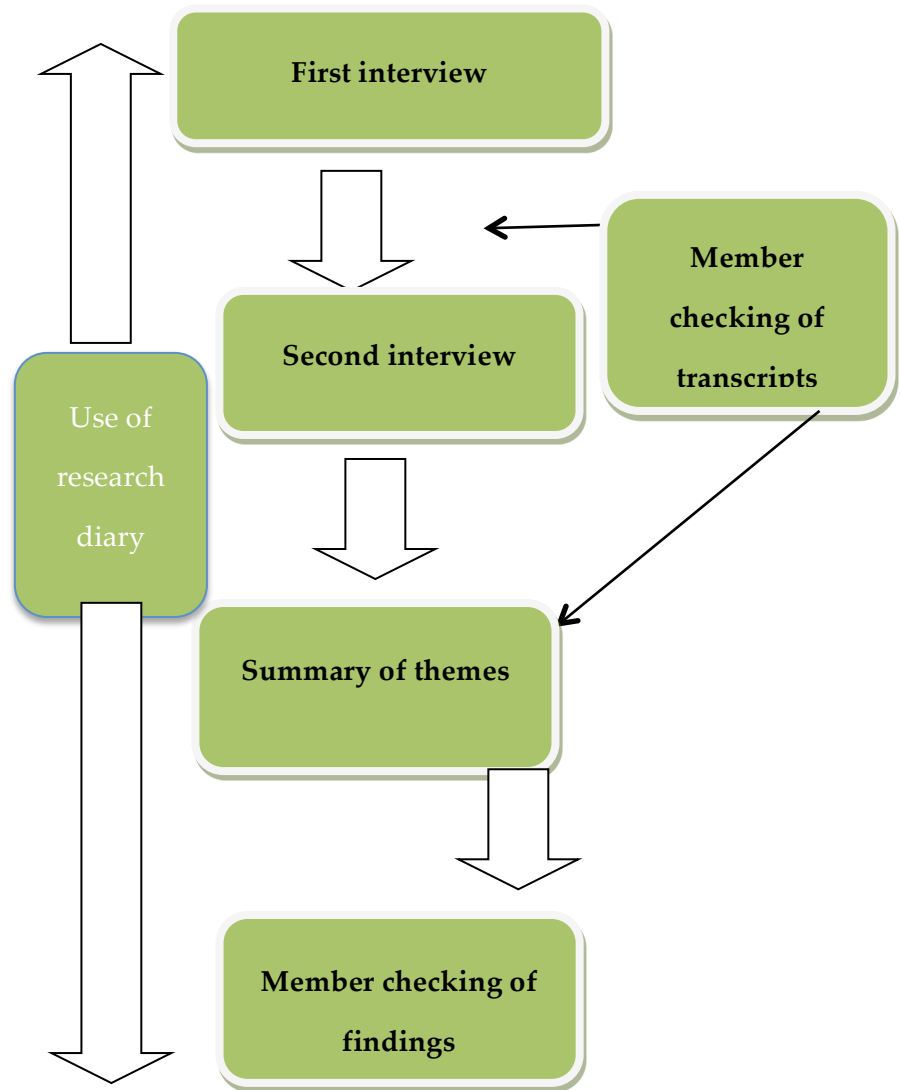


Figure 5.1: Research design and methods used

Research Diary

To assist in my reflexivity, throughout the study I kept a research diary in which I recorded my methodological and theoretical decision-making processes, and feelings and reflections about the research process. These reflexive notes minimised the risk of the methodology's appearance as a seamless thought process as they revealed the stages in decision-making documented in this chapter (Silverman 2000). My notes were used as data within the findings and the discussion of the thesis.

Chapter 5: Methodology

During the research process, I recorded my discussions with fellow researchers, ideas and notions about the research process, and anything else pertinent to data collection and analysis (Gibbs 2007). These included: the dates and location of interviews, details of the interviews, a record of my reading and its contribution to the literature review and analysis. These notes were kept as a series of five reflective diaries.

In addition to recording the interviews, I allowed time after each interview to make field notes in my research diary which included my immediate recollections of the interviews. These notes often took up to 90 minutes to write. They included a description of the participant, the interview setting, and reflective notes on my fieldwork experience and methodological issues (Minichiello et al. 1990). My research diary notes also included records of gestures, body language, expressions, and demeanor. I also noted other distractions: phone calls, interruptions by other staff, and alarms. These notes allowed me to record images of the workplaces. They contained my initial thoughts about each participant's interview, events, or situations, and the environment in which the interview took place, and the emerging themes (Wengraf 2001). I recorded the new hunches being generated and these helped form the questions and identified the issues to be addressed in the next round of interviews. This was the first stage in the analysis process (Wengraf 2001).

In qualitative research, and within the interpretivist and constructivist traditions, there is an acknowledgement of the key role reflexivity plays in interpreting the data. My interpretation of data was thus, 'co-constructed' and influenced by my own worldview as a researcher, an occupational therapist and educator. The field note data incorporated my assumptions and biases, perspectives, and theories. The use of a research diary assisted in documenting the impact my own background had on my assumptions about theoretical knowledge. These notes reflected my view of the world and allowed me to note connections between interviews. They assisted in

the reflexive process. These reflexive procedures required personal reflection and critical questioning (Finlay 1998).

During the analysis, the entries in my research diaries acted as mental notes to help me remember the what, why, who, where, and when of my data collection and to record my interpretations. As Gibbs (2007) notes, this descriptive writing assisted in my reflection, interpretation, and sense-making. These recollections assisted during the analyses of the data, as they reminded me about the conditions of each session, where it took place, and whether the participant was hurried or distracted within their environment. My field notes are securely stored, with the interview data and are open to audit. These notes were treated as a source of analysis and interpretation. The process of writing in my research diary allowed the differentiation between what happened, and the analysis and interpretation of the data.

In-depth Interviews

Within narrative inquiry, there are different mechanisms of gaining access to a person's story. I chose to use in-depth semi-structured interviews to collect the participants' professional histories because they are particularly useful when the phenomenon under investigation cannot be observed directly, and because the intention was to find out how participants thought or felt in relation to a given subject (Lincoln & Guba 2003; Silverman 2000). This form of interview allowed the participants to tell their professional histories on more than one occasion, and for more in-depth probing of the issue to happen in the second interview (Holloway & Freshwater 2007). Furthermore, the two interviews and the review of transcripts allowed time for participants to reflect upon the influence which career experiences had on the knowledge they valued and used in daily practice. Thus, engaging in two semi-structured interviews allowed each participant to tell their professional history, for me to trace the progress

and influences of their experiences on their use of theoretical knowledge, and to hear their more immediate practice stories. These stories also provided an insight into how colleagues, teams, and policies influenced the value and use of theoretical knowledge in practice.

Two interviews were held to capture each participant's experiences and explore the range of issues affecting the theoretical knowledge valued and used in mental health practice by the participants. As discussed above, this was comparable with other studies into theoretical knowledge in which in-depth interviews were employed to collect data (Eraut 2007; Holloway & Freshwater 2007). The content of these two interviews is described below. My initial aim was to complete all the first interviews, member checking and analysis prior to the second interviews, and to conclude the data-gathering process with further member checking of preliminary findings. However, my timeline for these plans was lengthened because during the study, three participants either changed jobs or took personal leave. All the first interviews were completed in 2009, and the second interviews in 2010—six to nine months after the first. Interviews ranged from 90 to 160 minutes. The time frame for data collection is illustrated in Table 5.4.

Table 5.4: Timeline for data collection

Action	Time frame
Ethics approval	July 2008
Sample recruitment	December 2008
First interview	February-December 2009
Second interview	August 2009-December 2010

All nine occupational therapists, who volunteered were interviewed twice. The participants' prolonged engagement with the research meant they were able to engage in member checking, and had time between interviews to reflect on their experiences and consider what had influenced their valued and used theoretical knowledge. Thus, each participant was invited to engage in four processes: (i) the first in-depth interview; (ii) the member

checking of the first transcript; (iii) the second in-depth interview and (iv) the opportunity to further check and comment on the transcript from the second interview.

Phase.1: The first in-depth interviews

The first in-depth interview aimed to elicit each participant's professional history through his or her recall of episodes and case-based stories about the phenomenon under study, i.e., the knowledge valued and used in practice and influences on its use and value. The interview took the form of a semi-structured interview, and allowed for interaction in the form of an informal conversation. The interviewing techniques and questioning style employed were strongly influenced by a single narrative interview question based upon a biographical-narrative style and were designed to elicit professional histories from participants (Wengraf 2001). To do so I used Wengraf's (2001) framework for narrative interviews to convert my research questions into open-ended questions to capture the participants' professional histories. Before the interview, I transcribed my 'theoretical research questions' into more colloquial forms (see Appendix IV for a copy of the interview schedule). This process resulted in short questions, devoid of academic language, which generated spontaneous and rich description (Wengraf 2001). These questions aimed at capturing participants' description of their practice in previous workplaces, and avoided direct questions about theoretical knowledge. This avoided a known source of confusion through the use of theoretical language and terms (Fargion 2007). This style of interview also allowed for flexibility in terms of the areas explored, order of questions and opportunities for the clarification of meanings (Darlington & Scott 2002).

To ensure sufficient time was allowed when appointments were made for each interview, participants booked a 180-minute period with the proviso this would be the maximum time commitment. This allowed time to build

rapport and provided an opportunity for participants to tell me about their careers in occupational therapy and reflect on how their career paths had influenced their use of knowledge in practice.

All the participants chose to be interviewed at their workplace which provided insight into their sociocultural environments, and a sense of how their physical spaces affected their practice. Their work environments included quiet office spaces, clinical interview areas, and shared offices permitted observations of participants with colleagues.

I scheduled the first round of interviews between February and December 2009 to fit with each participant's busy schedule and leave allocations. Two interviews had to be cancelled on the day because of incidents in workplaces, for example lack of staff to cover duty rosters. Rearranging these meetings delayed the planned schedule but allowed more time for my reflection about the interview process. Each interview was recorded digitally. At the beginning of each interview, the participant was informed they could turn off the recorder if they wished but none chose to do this.

In the first interview, I captured each participant's professional history. I wanted to know whether different mental health settings had affected their choices of theoretical knowledge. I began each interview by asking participants to tell me their professional history—the story of their career—from their entry-level education through their work careers up until the time of the interview. The first two participants began their stories at a point before the commencement of their professional education program. This led me to ask subsequent participants to begin their stories with how they had initially chosen to study occupational therapy. I realised this was important, as it established their connection to the profession. I asked how important occupation and occupational therapy was to them, their family, and their friends.

I had initially anticipated asking a few 'grand-tour' questions with prompts to capture professional histories and then to explore how theoretical knowledge was embedded into practice by asking participants to describe case-based stories. In the first interview with Bronwyn, it became clear I would have to adapt this plan. Although Bronwyn wanted to tell me her story and could illustrate her use of theoretical knowledge in practice, it became clear she segmented her story into mini-episodes in mental health workplaces. This required more prompting as I asked for case-based illustrations from each career 'segment', or episode. Each interview therefore took the form of a directed conversation in order for me to prompt the participant to move between these episodes and make connections between them (Wengraf 2001). Thus, while the beginning of each interview was similar, the structure of each was determined by the conversation with the participant. This elicited descriptions, or accounts of their experiences of practice illustrating the knowledge valued and used (Wengraf 2001). It became clear their career stories had begun before they entered university when they were first introduced to the profession of occupational therapy through various life events. I thus asked them about this period prior to their professional education as well as the influences of their university program.

The range of career histories ensured I had to approach each participant's story from different angles while maintaining consistency with the research questions I asked. These questions built on participant's responses to the opening grand-tour questions and I then explored how the participant valued theoretical knowledge in their practice, and the influences on how and when this knowledge was used. Following participants' initial accounts of formative episodes in their professional career, I directed the interview to elicit more detailed responses. Thus, I attempted to connect each episode into a professional history, to find the meanings assigned to events and experiences, and explore the complexities influencing their

behaviours and values (Wengraf 2001). To encourage participants to provide personal accounts of events in their own words, with minimal prompting I ensured the main prompt questions were descriptive: What happened and how did it happen? How did you feel then? What did you experience? To ensure I covered the same topics, I steered the conversation back towards the interview questions (Clandinin & Connelly 2000) as I tried to capture 'spontaneous, lively, and unexpected answers from the interviewees' (Kvale 1996, p.129). The focus and structure of the second part of the interview was determined by the information revealed through the participant's conversation. The exact content of each interview was thus influenced by the participant's account of his or her practice experiences (Clandinin & Connelly 2000).

After the first round of interviews, the digital media files were sent to a transcribing service and the interview was transcribed verbatim. After transcripts were returned, I removed all identifiers. Each participant was sent a copy of his or her interview transcript. This provided an opportunity to verify the accuracy of the transcript's contents. No participants required amendments to the transcripts. This process also allowed participants an opportunity to reflect on the influence of their career experiences on the theoretical knowledge valued and used in practice.

Following the first interview, I incorporated the practice of drawing a time-line to illustrate the participant's professional history. I found this time-line drawing provided a visual representation which allowed me to think more deeply about how episodes were connected and to visually represent the participant's use of theoretical knowledge at each stage in the story. Initially, these drawings helped me to understand each participant's career pathway and plot if the use and valuing of theoretical knowledge had changed over time. Thus, this drawing formed part of my interpretation of the findings. I also used these time-line drawings as a reference in the

second interviews to show the participants and to clarify details of work history, and to check I had entered the correct dates.

Phase 2: The second in-depth interviews

Following transcription and verification of the first interview, the participants were invited to attend a second interview. Each of the second interviews included questions about specific forms of theoretical knowledge and how it was valued compared to personal, professional, and factual knowledge as presented in Chapter 2 in Figure 2.1 (Trevithick 2012), and what challenged or supported their use in practice. I also asked how theoretical knowledge was combined with other forms of knowledge, such as information from factual evidence-based practice. Through this second interview, I was able to clarify and deepen my understanding of the participants' use of different forms of theoretical knowledge. This allowed further insight into how theoretical knowledge was used and what influenced its use to guide practical actions.

I had also completed the data analysis of the participant's first interview. The second in-depth interview focused on revisiting the participants' professional histories and further exploration of the forms of theoretical knowledge they used. This interview provided an opportunity to explore participants' reflections on the first interview. During the second interview participants were also asked to provide member checking on my initial interpretation and analysis of the first interview.

The two interviews allowed for a deeper exploration of each participant's experiences as trust developed over this time and new information was more readily obtained. I began each of the second interviews with time for the participant to comment on their first interview transcript and their reflections on the first interview. The interview process, combined with the opportunity to read their transcript before the second interview, provided time for each participant to reflect on their whole career. At the time of the

second interview, I asked each participant to check my record of his or her demographic information. The purpose was to check whether I had missed any significant information during the first interview and to refocus and gain more insight into the influence of episodes in their professional history. As a visual prompt, each person reviewed the time-line drawing I had completed following the first interviews to depict career paths and significant events. This drawing reminded participants of dates, lengths of service, career moves and experiences.

Following my initial analysis of the first interview data, I had drawn a figure to represent my early interpretation of the spectrum of value placed on occupation-focused theoretical knowledge (see Figure 5.2 reproduced below).

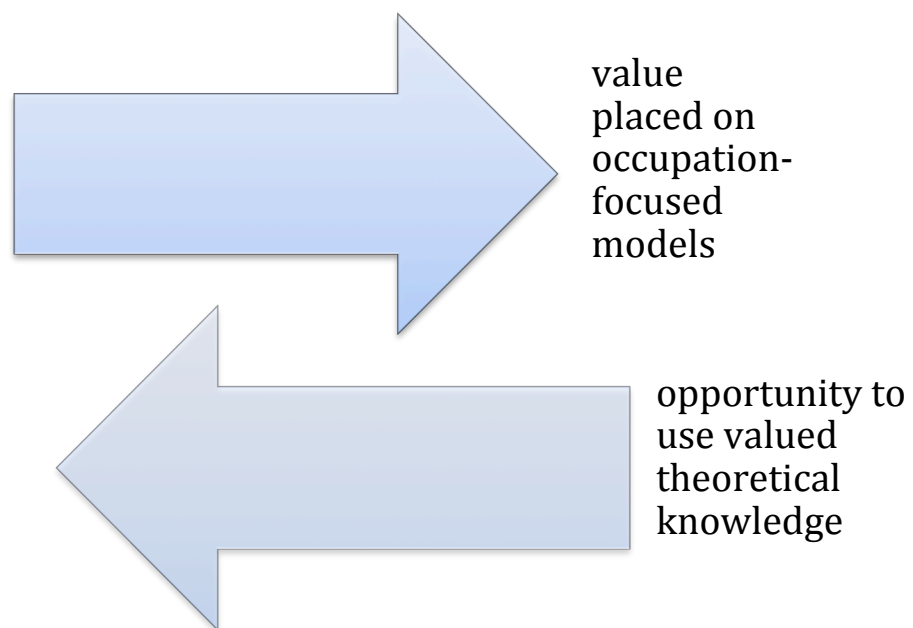


Figure 5.2: Spectrum of valued and used theoretical knowledge

Chapter 5: Methodology

In the second interview, I used this figure to initiate discussion on the value placed on occupation-focused models and psychological theories and their use in practice. This also gave participants an opportunity to discuss whether, or how, this spectrum had changed during their careers. Participants reported this Figure and the time-line drawing helped them to reflect on my interview questions.

In the second interview member checking also included the use of summary sheets of previous responses to prompt discussion about my preliminary findings with each participant. I asked participants to comment on the findings, ask questions, and make additions throughout the discussion.

I had asked participants to book a minimum of 180 minutes for the second interviews. In general they took longer than the first and lasted from 120 to 180 minutes. I think this was because participants had considered factors that had influenced their practice knowledge for the first time. This second interview allowed them more time to reflect and discuss how each episode from their professional histories had influenced the theoretical knowledge they valued and used.

After the second interview, the media files from the digital recorder were sent to the transcribing service and the interview was transcribed verbatim. After transcripts were returned, I removed all identifiers and sent each participant their transcript. Again, no participants made any edits or amendments to the transcripts.

Phase 3: Member checking

In addition to the opportunities to amend the transcripts, participants discussed the themes, which had emerged from the first round interviews and the data analysis. Each participant was invited to comment on the analysis and interpretation of the data. This allowed participants an

opportunity to disagree or present their viewpoint on the issues which impacted on theoretical knowledge use. This process of member checking became the starting point for the second interviews. It provided an additional time for their reflections on the similarities and differences between my analysis and their use of practice knowledge (Darlington & Scott 2002).

Stage 5: Data Analysis

Within the professional histories, I was able to analyse how participants' changing social environments, and the changing role of the practitioner within these different environments, influenced the application of theoretical knowledge (Wengraf 2001). To assist in the storage and analysis of the data, I entered the verified transcripts from each interview and the transcribed field notes from my research diary into a computer-assisted qualitative data analysis software package, NVivo 9 (QSR). The use of NVivo 9 ensured analysis, management, and storage of data were efficient. It also acted as a means of coding stored memos and field notes. Sound files were also retained and stored in the NVivo 9 file. This allowed me to listen to the recorded interview while I read the transcripts. I then used NVivo 9 to code and analyse this data.

The data analysis and interpretation began immediately after the completion of the first interview with the first participant and continued until the completion of the study. All the data were used to develop my analysis of the phenomenon under study, namely, practitioners' use of theoretical knowledge to guide practice (Bowling 1997). This process was systematically and thoroughly documented in my research diary and within the NVivo 9 notes section (Richards 2005).

The iterative process is described in Figure 5.3 (see below). This process involved working back and forth between the data and the literature. I

began the analysis by coding the data into themes, concepts, and categories. Through this process, I followed the steps outlined below.

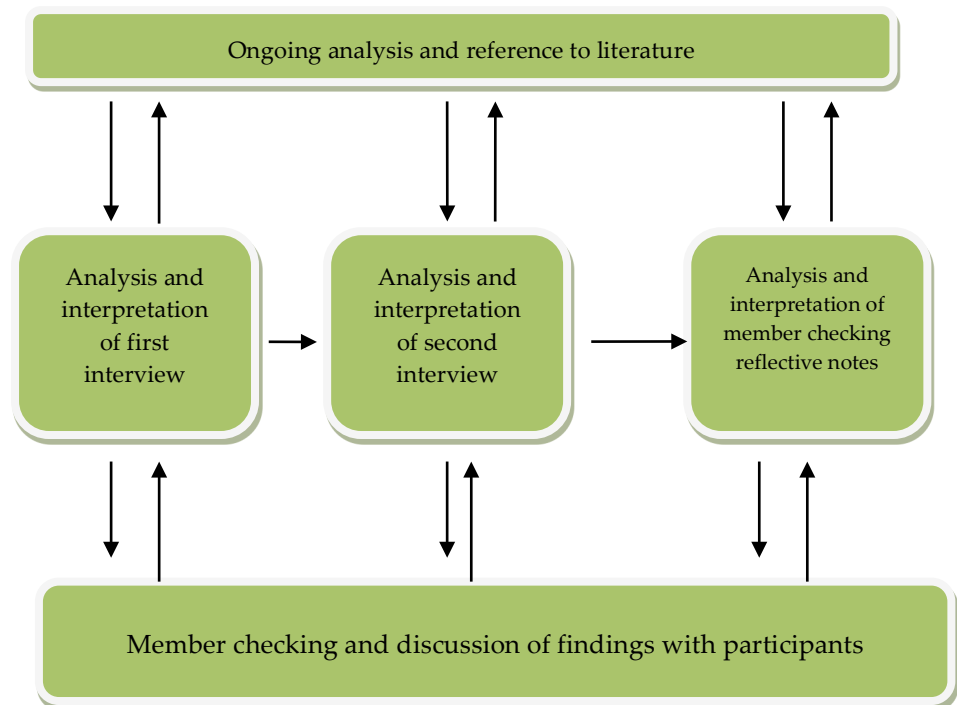


Figure 5.3: Iterative process

The processes involved in the coding of the data are discussed below and are summarised in Figure 5.4.

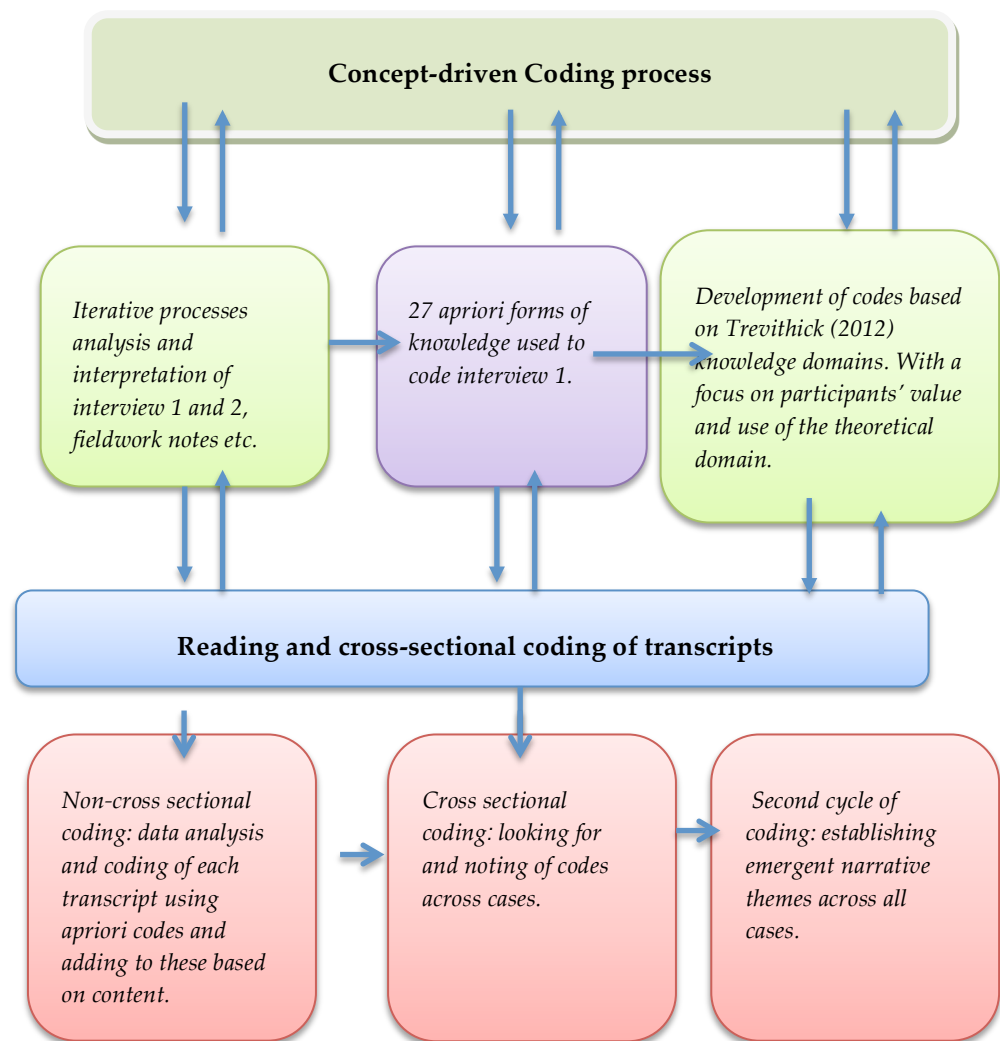


Figure 5.4: Stages involved in the coding of the data

They included pre-reading, concept-driven coding: the development and redevelopment of apriori codes to identify the use of different forms of knowledge.

The first cycle of non-cross-sectional (case by case) coding was focused on coding the use of different forms of knowledge, the influence of environmental factors created by people, workplace settings, events, the use of different forms of theoretical knowledge, and identification of case-based illustrations.

Following the review of the literature, I decided to employ Trevithick's (2012) original framework (see Figure 2.1, p.39) in the initial coding of the

data. Trevithick's (2012) framework fitted well with the interpretivist-constructivist approach adopted in this thesis (described in Chapter 4). Trevithick's framework acknowledges practitioners' values shape their use of knowledge in health and social care, and its application in specific contexts. They evaluate its utility in particular clinical settings. Ultimately, this knowledge, combined with service-user knowledge from clinical interactions guides the practitioner's chosen course of action (Milburn & Colyer 2008).

Rereading was followed by the second cycle-cross-sectional coding to identify similarities and differences and common themes – the 'implicit topics, which organise a group of repeating ideas' (Silverman 2000, p. 139)

Step 1: Pre-reading

Before I sent the transcripts back to each participant, I read and de-identified them. This first reading allowed me to make notes about what I considered important about each participant's descriptions, and to conduct an initial analysis. This occurred sequentially after each first interview transcript was returned.

Step 2: First cycle coding – developing concept-driven codes

The informal iterative processes involved in data analysis and interpretation began on completion of the first interview with the writing of my fieldwork notes. Initially, I used concept driven coding (Ritchie & Lewis 2003) to document codes I drew from the literature, previous studies, and personal hunches from my initial reading through of some of the transcripts, and the field notes in my research diaries. Ritchie and Lewis (2003) advocated the use of this framework analysis which led to the development of a list of key ideas, or 'apriori' codes. Through the analysis of the data these codes were amended when new ideas and ways to categorise the text were detected.

Initially, my list of apriori codes drew on the 27 forms of knowledge described in Fish and Cole's heuristic (2005). It became clear these were too specific and their use in the analysis led to a fragmentation and a loss of meaning. This led me to seek another method of analysing the forms of knowledge used in practice. I returned to the literature, and, as noted in Chapter 1, began the process of recoding the data using Trevithick's framework (Trevithick 2008a; Trevithick 2012). I then grouped the initial coding of knowledge use and value under the domains of: theoretical, practical, factual, professional, and service-user knowledge. I developed these codes into a conceptual schema of knowledge domains with a focus on participants' value and use of the theoretical knowledge domain. In this schema I elevated personal knowledge from 'professional knowledge

domain' to the adapted framework, which is represented below, and guide the reading of this part of the thesis. The participants' references to personal life experiences were coded into the 'personal knowledge domain'. These included references to their pre-program affinity to the profession and personal experiences or life events.

In addition to identifying the forms of theoretical knowledge valued and used by each participant, I also identified the factors within their environments influencing their valuing and use of the theoretical domain. I coded these factors and grouped external and internal constructs, which impacted on the value placed on the theoretical knowledge domain, and its use in practice. At this stage, I referred to professional identity and professional confidence as internal constructs in contrast with the external constructs: influences of policy and service delivery methods, the opinions of colleagues, and validation or lack of validation.

Further, I referred to the participants' case-based stories to analyse (i) the different forms of theoretical knowledge used, and (ii) how this use shaped participants' practical actions. The analysis of practical actions allowed me to identify how psychological theories, occupation-focused models, and occupational therapy's professional philosophical concepts and assumptions were used to guide these actions. This led to the further coding of instances and examples from participants' stories in which theoretical knowledge was used: (i) as a conceptual framework for interventions – as a higher order means of conceptualising the service-users' issues, and (ii) as a more direct or instrumental framework – when it directly influenced practical action through assessment, intervention, or evaluation (Townsend & Polatajko 2007).

Step 3: Reading and cross-sectional coding of transcripts

Following the first read through, I began the interpretation process Morse (2004) described as 'a relentless search for answers' by piecing together

data and making the 'invisible obvious' (p. 1387). This iterative process and inductive analysis continued throughout (Denzin & Lincoln 1994). For the analysis and organisation of the data, I used a combination of two methods: (i) in-situ, non-cross-sectional coding, and (ii) cross-sectional coding, and retrieval methods (Ritchie & Lewis 2003). The coding from these two methods was documented using NVivo 9 (QSR).

The first method I used to analyse the data was in-situ non-cross-sectional coding. This involved reading the particular parts of the data from each participant. For example, I reviewed all the data from one participant's interviews, her member checking document, and my field notes. This method of coding allowed for the interpretation and analysis of narratives, and of themes, which did not appear in all parts of the data (Ritchie & Lewis 2003). This method was combined with the cross-sectional method of coding.

The second, cross-sectional method of coding the data involved devising a series of categories which were systematically applied across the whole data set (Silverman 2000). I used in vivo concepts to describe emerging themes, i.e., concepts based on the language and terms used by the participants, with some chosen to represent common-sense terms, terms influenced by the literature and devised to capture the essence of talk and interaction (Saldana 2009). These included their descriptions of protective factors when referring to the strategies of 'knowing when it's time to go,' 'becoming professionally bilingual,' which maintained professional resilience. It also included descriptors of the accumulation of techniques in a 'professional toolbox'.

As the analysis and interpretation proceeded, these categories were used as a means of searching for, and retrieving coded data. This process offered a systematic overview of the data and found themes across all data sets. This enabled comparisons with, or connections between, participants' data

(Richards 2005) and assisted with the description of similarities and differences between participants' data. The analysis and interpretation also integrated the current research literature with the data from the interviews (Silverman 2000). This led to the second cycle – the analysis of themes.

Step 4: Second cycle coding-Analysis of themes

This step involved the further analysis of all the participants' first interviews and professional histories for common thematic elements. The location of themes was also based on their reported valuing and use of theoretical knowledge, the influences of events and workplace issues, and the actions they reported taking (Reissman 2008). This process of categorisation of the data set into themes resulted in higher level constructs which identified 'pools of meaning' (Saldana 2009). In turn, I identified or constructed concepts from prior material, theoretical frameworks, research questions, and the data themselves (DeSantis & Ugarriza 2000).

Within the analysis, these themes emerged as abstract entities, which brought meaning and identity to recurrent patterned experiences of theoretical knowledge and its variant manifestations. For example, the patterns which emerged from all the participants' professional histories were the interconnectedness and impact of professional identity, and professional resilience strategies on the use of valued occupation-focused models in practice.

At this stage, I further considered how the interplay of different aspects of the participants' environments and how these shaped the use and value of different forms of theoretical knowledge. To do so I employed Bronfenbrenner's (1979, 1986) work on social ecological models, which framed the themes into the macrolevel, mesolevel, and microlevel environments. In addition, Foucault's (1980) concept of dominant discourses was used to analyse the external pressures on the themes. To further analyse the emerging themes, I considered how concepts from

Habermas' (1972) *Knowledge and Human Interests* could identify the socionorms and the emancipatory nature of what underlay and shaped participants' personal choice of theoretical knowledge. Hence, Habermas' concepts added another dimension to my interpretation and analysis of what motivated a participant to engage with certain forms of theoretical knowledge, i.e., community, practice norms, or emancipatory forms of knowledge.

Step 5: Narrative thematic analysis

As described earlier, a range of methods can be used for data analysis in narrative inquiry, so it was important to review these for their suitability and application to this study. I chose to use narrative thematic analysis based on the work of Reissman (2008), Holloway and Freshwater (2007), and Clandinin and Connelly (2000) to guide the interpretation and analysis of the narrative data.

In keeping with the interpretivist-constructivist approach, I used an ideographic method. While themes were identified during the analysis, each participant is considered as a unique case. This method of interpreting the data is commonly associated with narrative inquiry as it acknowledges although two participants might have much in common, i.e., the same entry-level programme and experience of the similar workplaces and contexts, these factors were likely to combine to have different influences on the knowledge used because of the participants' diverse social backgrounds, workplace experiences, and differing personalities (Gibbs 2007). Thus, in the findings chapters I have tried faithfully to reflect the interplay of events, place and setting specific to the individual participants which formed the unique nexus, which influenced the use of forms of theoretical knowledge in practice (Gibbs 2007).

I also identified whether participants highlighted factors as shaping their valuing and use of different forms of theoretical knowledge. Thus, during

all the steps in the process of data analysis and interpretation, I considered how each participant's different professional history appeared to shape their current use and valuing of theoretical knowledge in practice.

Step 6: Adding and coding new data

I entered the second interviews into NVivo 9 and read and coded these interviews using the techniques described in the previous first and second cycle coding steps. No new themes emerged during this process and transcripts were analysed using the existing codes. At this stage, I also reread my research diary notes to see if there were any additional data to include in the analysis process.

Step 7: Rewriting and cross-analysis of themes

During this step, I reread the codes and themes with information from the literature and developed new understandings which I incorporated through the process of writing the final chapters for this thesis.

Stage 6: Dissemination and Writing of Thesis

The preliminary findings were presented in peer-reviewed conference presentations (Ashby 2010a; Ashby 2010b; Ashby 2011a; Ashby 2011b; Ashby, Gray & Ryan 2012). These presentations offered another form of questioning and critique on the themes and interpretations drawn from the data from the broader occupational therapy community of practice. The informal feedback from those practitioners who attended these presentations was positive and indicated general agreement with my findings on the factors which were seen to shape the value and use of different forms of theoretical practice knowledge in mental health practice.

Trustworthiness of Findings: Application of Quality Assurance Criteria

While there is no consensus about the way in which quality assurance is applied in qualitative research, auditability is an important feature (Tobin & Begley 2004). Tobin and Begley noted the lack of consensus regarding the necessary qualities of qualitative research is partly due to the language used within different philosophical perspectives, as language is the basis on which philosophical beliefs are articulated and communicated.

In response to debates about the use of the terms 'validity' and 'reliability', Lincoln and Guba (1985, 2003) developed the concept of trustworthiness to reflect the values, beliefs, epistemology, and ontology of the interpretivist-constructivist paradigm. They suggested trustworthiness is demonstrated through credibility, transferability, dependability, and confirmability (Lincoln & Guba 1985; Lincoln & Guba 2003). However, as noted by Tobin and Begley (2004), even the concept of trustworthiness has been challenged in the literature with arguments that the concept of 'checking' interpretation was 'antithetical to the epistemology of qualitative inquiry and reveals philosophical inconsistencies' (p. 393). This was addressed by Guba and Lincoln (1994) through their introduction of authenticity as a fifth criterion.

In occupational therapy, the notion of trustworthiness has been applied to qualitative inquiries (Gliner 1994; Krefting 1991) and I have adopted this term in my study, and this criteria into my research design. I regarded this as a key step in the design as it is important the quality of qualitative research is not seen as a separate construct, but as an integral and embedded component of the research process and is reflected in the entire study (Tobin & Begley 2004). It was important throughout the study that an audit trail of documentation was recorded to allow others to review the

processes and ensure the overall trustworthiness of the procedures I used at each stage. The study was carried out ethically, and the findings represented as closely as possible to the experiences of the participants (Lincoln & Guba 1985; Padgett 2008). A selection of the participants' experiences are represented in the dissertation as professional histories and with direct quotations to support the interpretation and presentation of themes and to retain the context in which their experiences and uses of theoretical knowledge were described.

Credibility

The concept of trustworthiness includes the criterion of credibility and is comparable with internal validity in quantitative research (Tobin & Begley 2004). Credibility in qualitative research requires a researcher to 'establish confidence in the "truth" of the "findings"' (Lincoln & Guba 1985, p. 290). In qualitative inquiry, credibility is demonstrated through strategies, which confirm sound research practices were used. The strategies outlined by Lincoln and Guba (1985) included: (i) opportunities for prolonged engagement with participants and (ii) participants' validation of findings through member checks. It also includes peer debriefing and audit trails to ensure that the interpretation of data is clear (Lincoln 1995).

In this study, my engagement with the nine participants extended over a two-year period. After each of the two interviews, the participants were sent a copy of their transcript for member checking to verify its accuracy (Whittemore, Chase & Mandle 2001). In addition, during the second interview, the participants were asked to comment on my analysis and interpretation of the themes which had emerged from the first interviews, my time-line drawing of their story, and the spectrum-drawing. This additional member-checking process involved participants being asked for their opinions and comments at the beginning of the second in-depth interview about my interpretations and emergent themes.

As mentioned earlier I also used my supervisors for peer debriefing, and to discuss the development of my interpretations of the findings. These discussions were recorded in my research diary. In addition, my notes and reflections during interpretation were noted in my diary and in NVivo 9 (QSR). These formed part of the audit trail that allowed me to make clear the steps involved in my interpretation and analysis of the data in my presentation of the findings in Chapters 6 and 7 (Lincoln & Guba 1985).

Transferability

Transferability is comparable with external validity in quantitative studies and refers to the degree to which the findings could apply in other contexts (Lincoln 1995; Tobin & Begley 2004). In this research, experienced occupational therapists were purposively selected, and while the study is located in one geographical area of Australia, the contextual data are clearly represented so others can assess the transferability of findings to their own research or practice settings. I have presented this contextual data at occupational therapy conferences in Britain, Canada, and Chile to international audiences (Ashby 2010a; Ashby 2010b; Ashby 2011a; Ashby 2011b). The audience responses to the findings and interpretations were positive, with comments indicating the influences and issues faced by the participants reflected the challenges facing other occupational therapists in mental health practice.

Dependability

Dependability of findings in qualitative studies is achieved through the process of auditing which requires the process of research be logical, traceable and clearly documented (Schwandt, 2001). The dependability of this study can be demonstrated through my audit trail as my documentation of data, methods, decisions and end product in my research diary and in NVivo 9 can be examined (Tobin & Begley 2004). Reflection

and reflexivity were also central in my audit trail, and I have kept a self-critical account of the research process within my research diary and within this thesis.

Confirmability and authenticity

The concept of confirmability is concerned with ensuring that the data, and interpretations of the findings are clearly derived from the data rather than from the inquirer's imagination (Lincoln & Guba 1985; Tobin & Begley 2004). This was achieved through peer debriefing, an audit trail, member checks, and by presenting the range of different realities, participants' concerns and underlying values contained within findings.

In this study, the confirmability and authenticity was addressed through the close attention paid to the meanings of participants' words, through listening to the audio files and repeated reading of the verbatim transcripts. The confirmability and authenticity of the study were strengthened through an audit trail, which included the systematic documentation of each stage and step in the research process (Padgett 2009). This included the use of a research diary to record my thoughts and reflections throughout the interpretation process. I also recorded peer and supervisory briefing meetings during the data analysis and interpretation. Furthermore, member checking by participants allowed them to provide feedback about my interpretations and to comment on the summary of my findings. While member checking ensured the confirmability and authenticity of my research I acknowledge this process was limited by multiple realities.

Limitations of the Study

While care was taken to minimise the limitations of the study through the research design, there are considerations to acknowledge and note. The study's sample was limited to the number of occupational therapists who

volunteered. Likewise, I deliberately chose to contextualise the study by focusing on occupational therapists in mental health practice in a particular area to develop an in-depth understanding of their practice. Thus, the sample was located in one public health region in NSW and this may reduce transferability to practitioners in other services, or locations. While in this location, practitioners had the freedom of choice regarding occupation-focused models so the findings may not be transferable to practitioners who work in services, which adopt the explicit use of one occupation-focused model. The contextualisation of studies in particular locations is not uncommon in qualitative research but may impact on the transferability of the findings to other occupational therapists. This might limit the transferability of the findings, but for the purpose of this qualitative study, the benefit of understanding their lived experience outweighed issues with generalisability. While I sought to represent their experiences as closely as possible, the inclusion of those working in other health areas may have led to different findings.

My choice to use interviews to investigate the use and value of different forms of theoretical knowledge in practice may have prevented some practitioners, who may have found this stressful, from participating. In addition, retrospective data collection of the participants' reflections about their use of theoretical knowledge may have altered their recall and influenced their narratives. My choice to use interviews to gather the data allowed the comparison, contrast and identification of factors in workplaces, that shaped theoretical knowledge. However, there was also a lack verification or corroboration from colleagues, or service users.

Conclusion

The research into the use of theoretical knowledge by occupational therapists in mental health practice has been limited and the few existing

studies employed quantitative methodologies (e.g. Bartlow & Hartwig 1989; Haglund et al. 2000). Hence, I utilised a qualitative research approach and narrative inquiry to uncover the influence of forms of theoretical knowledge on mental health practice and on the thinking and practical action of occupational therapists.

In turn, I explored how episodes in the participants' professional journeys changed the forms of theoretical knowledge, which they valued and used during their careers. The use of in-depth interviews and reflections proved effective in unearthing how theoretical knowledge is integrated into praxis and phronesis. They also revealed the conceptual use of occupation-focused models in the tacit dimension of practice.

The commonalties in their professional histories also demonstrated how their use of theoretical knowledge was crucially shaped by their differences in professional exposure to practice settings in which they were employed (Gibb 2007). In addition, the participants' professional histories also revealed the explicit, implicit, and tacit ways in which different forms of theoretical knowledge were used in their occupational therapy mental health practice. Through employment of these methods I came to better understand the complex ways in which knowledge, experience, and values were integrated and blended in practice. These findings are described in Chapter 6 and 7.

CHAPTER 6: FINDINGS PART 1— DEVELOPING PERSONAL PARADIGMS AND THEORETICAL KNOWLEDGE USE IN MENTAL HEALTH PRACTICE

In keeping with narrative inquiry, the findings in Chapters 6 and 7 distill the participants' stories about their professional journeys and attempt to represent these experiences as closely as possible. Throughout Chapters 6 and 7, in keeping with the ethos of qualitative research, I have demonstrated and supported my interpretations with stories and quotations derived from the data. The focus of Chapter 6 is on the practitioners' use of theoretical knowledge in their daily practice whereas, in Chapter 7, I present the underlying ways in which dominant discourses and sociocultural communities of practice were seen to shape the participants' use and value of theoretical knowledge.

Chapter 6 is divided into two sections. Section one represents the findings that reflected how different career stages were seen to shape the participants' development of their theoretical knowledge use and personal paradigms. Section two focuses on how the participants used theoretical knowledge in their practice. In this chapter, I show the participants' use of theoretical knowledge and how it was integrated with other forms of knowledge in practice. Thus, the chapter illustrates how participants used philosophical assumptions, occupation-focused models, together with frames of reference derived from psychological theories. It also explains how different career stages influenced their use of theoretical knowledge and influenced their personal paradigms.

Section 1: Professional Journeys and the Value and Use of Theoretical Knowledge

The first section of Chapter 6 describes the participants, and the common stages they experienced in their professional journeys. It begins with a description of the participants and their workplaces. While the participants' stories were particular to each individual, there were commonalities which were seen to shape choices in the value and use placed on different forms of theoretical knowledge and career progression.

The commonalities included:

- entry-level program curricula were the main source of knowledge about occupation-focused models due to the familiarity gained about specific models of practice and the opportunities to use them in case studies and other assignments.
- the accumulation of new theoretical knowledge through continuing professional education. Courses were chosen pragmatically, and participants focused on job-specific knowledge perceived to add value to their career progression. The chosen courses tended to focus on the learning of new therapy techniques drawn from psychological theories.
- the participants' professional journeys illustrated the importance of finding a job with the right match. This match was described as the opportunity to use valued theoretical knowledge to direct interactions with service users in everyday practice. The inability to find a match led to frustrations and challenges, which required the maintenance and use of strategies for professional resilience. Professional resilience and the strategies used to maintain it are discussed in more detail in Chapter 7.

Chapter 6: Findings—Developing Personal Paradigms and Theoretical Knowledge Use in Mental Health Practice

This section also presents how three participants used theory during their professional journeys by presenting the stories. These three stories represent narratives from across a spectrum of the participants' use of different forms of theoretical knowledge.

A Description of the Participants and Their Workplaces

As noted in Chapter 5, the purposive sampling and the specific inclusion criteria had called for participants with experience of work in more than two mental health settings. This criterion is reflected in the demographic information described in Table 6.1 which provides an overview of the range of workplaces each participant experienced. All nine participants had worked in a variety of mental health settings and their years of experience in mental health workplaces ranged between 5 and 30.

Chapter 6: Findings—Developing Personal Paradigms and Theoretical Knowledge Use in Mental Health Practice

Table 6.1: Participants’ practice context

Pseudonym	Years in mental health	Number of workplaces	Workplace	Service-user group at time of research interviews
Liam	5	2	Community	Adults
Bronwyn	8	5	Community	Children and Adolescents
Anna	1	4	Community	Adults
Megan	13	> 10	Community	Adults
Sarah	14	> 10	Community	Children and Adolescents
Diana	14	> 10	Community	Adults
Alex	17	4	Inpatient	Adults
Eliza	17	> 10	Inpatient	Management
Maria	30	3	Inpatient	Adults
Total	129	<58		

The Professional Histories: Commonalities

Participants recounted episodes from their professional histories rather than providing complete chronological stories. These episodes were often quite separate and distinct as they were constructed around practice experiences. These episodes can be referred to as ‘career stages’ (Reissman 2008). Each career stage was contextualised within time and place and was life changing in some way. The participants recounted the diverse ways in which, during these episodes, they had accommodated dominant mental health discourses within their occupational therapy practice. Participants had constructed ‘coherent and reasonable worlds of meaning’ to make sense of their experiences in mental health practice (Coffey & Atkinson 1996, p. 3). The structure of these stories is depicted in Figure 6.1 which

Chapter 6: Findings—Developing Personal Paradigms and Theoretical Knowledge Use in Mental Health Practice

shows that within an overarching professional journey, key career stages were seen and episodes recount key positions.

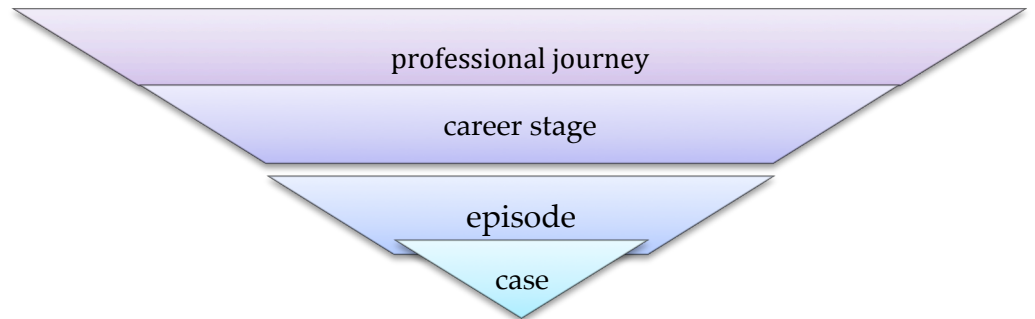


Figure 6.1: Structure of professional history

Each participant's story about their professional histories was informed by workplace experiences and consequent changes in professional identity. Particular common career stages in their professional journeys had important implications for how the participants valued or used different forms of theoretical knowledge. These career stages included: the participants' life experiences prior to entry-level programs, entry-level program experiences, the transition phase from student to practitioner that occurred in first jobs, and finding an ideal job. These stages are summarised in Table 6.2 which presents the factors from each stage, which contributed to the use and value of different forms of theoretical knowledge during their professional journeys.

Chapter 6: Findings—Developing Personal Paradigms and Theoretical Knowledge Use in Mental Health Practice

Table 6.2: Common career stages in professional journeys

Career Stage	Description
Pre-entry to program	Influence of personal experience of occupation. Coping with advice from others. Assessing acceptance with professional beliefs.
Entry-level program	Introduced to the professional knowledge domain of occupational therapy. Introduced to different forms of theoretical knowledge. Establishment of an affinity with mental health practice.
First job	Time of challenge for using occupational perspectives. Expansion of knowledge – battles and struggles and losing balance.
Ideal job	Journeying to find the right match between the value and use of theoretical knowledge. Developing experiential knowledge and strategies. Varying and increasing the use of valued occupation-focused theoretical knowledge when possible. Fitting in with teams and services. Removing self from intolerable workplace environments. Finding a good job – the right match between valued and used theoretical and professional knowledge.

Participants' professional histories reflected their personal paradigms. While these paradigms were peculiar to each participant, common narrative themes emerged about what constituted, influenced, and supported occupation-based paradigms. Participants lacked free time for reflection in their workplaces and reported that the interview gave them time to reflect on their careers and practice. This reflection had led to more critical evaluative thinking about the impact of different forms of theoretical knowledge on their practical actions, and what had influenced this during their career. Thus, the research design provided the opportunity to spend time thinking about, and reflecting on, practice and situations beyond the immediate focus of knowledge use (Coffey & Atkinson 1996).

In the context of participants' stories, professional identity and personal paradigms were associated with how the participants related to occupational therapy's professional knowledge domain—along with

Chapter 6: Findings—Developing Personal Paradigms and Theoretical Knowledge Use in Mental Health Practice

occupation-focused models from the theoretical knowledge domain. Furthermore, the participants' integration of these two domains of knowledge often defined their professional identity. Several participants described their professional identity as 'OTness'. This identity was either strengthened, or weakened, in the face of workplace challenges. Professional identity was also shaped by the participants' affinity with the profession before they began their professional education, or was developed during their entry-level program. This affinity with the profession varied. Participants with a strong personal affinity to the profession's core occupational perspective of wellbeing appeared to have strong professional identities. The following section describes the divergent professional journeys of three participants.

Three Stories From Across the Spectrum of Personal Paradigms

The stories of Diana, Alex and Bronwyn were chosen specifically because they illustrated how specific career stages shaped participants' use, and represented the diverse use of, theoretical knowledge within the context of mental health practice. They show the differences which existed across a spectrum between what theoretical knowledge was valued and used, with emphasis on the use of occupation-focused and frames of references drawn from psychology. Thus, the stories of Diana and Alex represent different ends of this spectrum, Bronwyn's story illustrates a more dynamic shifting of use and value of theoretical knowledge based on changes in her micro, and mesoenvironments.

Diana's story reflects the experiences of a practitioner who had sought and enjoyed jobs requiring minimal use of occupation-focused theoretical knowledge. In contrast, Alex had always felt comfortable with the notion of using occupation in therapy, and had chosen pathways which allowed him

Chapter 6: Findings—Developing Personal Paradigms and Theoretical Knowledge Use in Mental Health Practice

to use occupation-focused theoretical knowledge to his direct practical actions.

Bronwyn's story demonstrates how personal paradigms can be dynamic and dependent on the social norms of workplace environments. More recently, she had moved from using frames of reference from psychology towards incorporating occupation-focused models to create a more occupation-based practice.

The stories also illustrate the common challenge of working in biomedically, or psychologically dominated services. They illustrate how the attribute of professional resilience maintains the use and valuing of occupation-focused models and occupation-based practice. These stories illustrated the theme of professional resilience, which is explored in Chapter 7. Diana's story illustrates the part of the spectrum where a lower value was placed on occupation-focused theoretical knowledge and where the participant enjoyed working in more generic case-management roles.

Diana's story – Professional ambivalence

Diana's story reflected how her initial doubts about the profession made life within a community of practice difficult. On leaving school, Diana had always been interested in a career as a health professional. She had thought about podiatry, but this program was not available at her local university. This led her to enrolment in a nursing degree. Diana had not enjoyed this nursing program, she decided to move into an entry-level occupational therapy degree because it seemed 'more interesting' than nursing.

Throughout her career, Diana felt her professional identity, or 'OTness', was not as strong as others within her community of practice. This feeling had negatively impacted on her professional identity. Her membership of the community of practice was challenging, as it was made up of practitioners who seemed very confident and committed to the profession.

Chapter 6: Findings—Developing Personal Paradigms and Theoretical Knowledge Use in Mental Health Practice

This led to her concerns about reflecting on or revealing her ambivalence to other occupational therapists. These concerns, combined with her part-time status at the time of the interview, made it difficult for her to engage in professional socialisation events.

Diana's ambivalence centred on her lack of trust in some of the profession's assumptions. Her ambivalence began while at university as Diana had doubts about her acceptance of the profession's beliefs. Diana found occupational therapy's theoretical and professional knowledge domains were vague and abstract, but enjoyed applying practical skills and the experience of her mental health practice education.

However, she felt unable to discuss these doubts during her degree, as her perception was her lecturers were so overly positive about the profession. Her perception was that critique was not invited and she felt unable to discuss her doubtful career choice with them. These doubts continued during her professional practice education experiences. Her practice educators behaved like her lecturers. She considered they too were 'evangelical super-occupational therapists' with whom it did not seem possible to share doubts about the profession without 'looking less of an occupational therapist in their eyes'. She had also worried that raising her doubts could jeopardise her chances to pass the placement. Although she continually felt alienated from the profession, she saw a path into the mental health workforce through her occupational therapy degree, which is why she persevered. She noted she had

Purposely sought out a supervisor who meets my needs and we talk about these issues – my ambivalence and what I need to do to resolve that... whether it's just feeling more confident in what I'm doing or whether it's just me attaching to the OT community locally a bit better or what it is. So, supervision is valuable to me now that it's what I'm looking for (Diana—int ²).

On graduation, Diana considered her ideal job was to be a member of a mental health crisis management team in an acute mental health

Chapter 6: Findings—Developing Personal Paradigms and Theoretical Knowledge Use in Mental Health Practice

community team. This job became available immediately and was her first transition into practice after her graduation. Being in acute care, this work drew heavily on biomedical factual knowledge about psychiatric conditions and treatment approaches. The emphasis was on case management and there was a focus on reducing the service-user's symptoms. Diana considered herself an equal member of the mental health team in this setting and enjoyed this feeling. As this position was short-term, she had then moved to other jobs in mental health in which a predominantly biomedical approach was also used, and which also emphasised the case management rather than occupational therapy discipline-specific roles.

Diana then moved on to working in an inpatient rehabilitation unit. In this rehabilitation setting she had enjoyed 'pure occupational therapy' which had an occupation-focus. This emphasised the broader occupational issues and expanded the leisure and productivity aspects of service-users' lives. Although she enjoyed engaging in unstructured and creative occupation-based practice, she perceived that her nursing colleagues neither validated, nor respected her occupational therapy interventions. This experience in rehabilitation and her initial ambivalence to the profession led her to return to an acute community mental health setting. She was working in this setting at the time of the research interviews as a case manager and an occupational therapist, which allowed her to use her expert, factual, biomedical knowledge.

The acute community mental health team setting provided opportunity for fast-paced, valued interventions. However, this choice of work challenged Diana's professional identity, and the role blurring with others made her question her occupational therapy role. She observed her psychology colleagues and found herself longing for the apparent 'certainty' of working as a psychologist with an evidence-based manual, and having respect from others who validated the role. Diana noted in the interview

Chapter 6: Findings—Developing Personal Paradigms and Theoretical Knowledge Use in Mental Health Practice

she knew other occupational therapy friends who shared her ambiguous feelings about the profession, they too, after years of work as occupational therapists, sought other more fulfilling jobs. In her quest for more structured approaches, Diana considered the use of occupation-focused models could structure and create a stronger role and identity in her acute community mental health team.

As stated previously Bronwyn's story illustrates a professional history where a dynamic shift occurred in a participant's use of occupationally focused theoretical knowledge.

Bronwyn's story—Purpose, contradiction and confrontation—A dynamic shift

Bronwyn's career in occupational therapy began with her enrolment into an occupational therapy bachelor program. While a student, she worked for a non-government organisation that provided leisure and other meaningful activities to people living with a range of disabilities. These workplace experiences highlighted the important role occupational engagement played in wellbeing. She valued her education at university. While it could not replicate 'real-world situations' she enjoyed courses, which developed her clinical skills in group work theory and practice. University also provided opportunities to apply different forms of theoretical knowledge to simulated situations through case studies and in other assignments. Nevertheless, Bronwyn's most valued learning happened while on placement where she felt she learnt best by 'doing'.

After graduation, Bronwyn's first job was in an acute inpatient psychiatric unit. This context provided the benefit of working alongside two very experienced occupational therapists. They provided support, professional role modelling, and informal mentoring. Her job involved running a pre-existing program and she felt there was a clear professional role. While the occupational therapy role was clear, Bronwyn found the occupational

Chapter 6: Findings—Developing Personal Paradigms and Theoretical Knowledge Use in Mental Health Practice

therapy program was considered secondary to the pervasive focus on biomedical interventions. On admission, service users were unwell but demand for beds resulted in pressure on staff for early discharge. The criteria for discharge focused on symptom reduction through medications. Bronwyn felt many medics and nurses considered her role as secondary. Colleagues considered occupational therapy as less important as it provided service users with ‘activities for diversion’. Bronwyn felt these colleagues did not appreciate the therapeutic benefits of her interventions. To strengthen her position and justify her interventions she had sought research-based evidence. However, in the acute setting, and in her later roles, she had not found research evidence to support her occupation-based practice. She reflected:

We have clinical and rehab coordinators and ward staff looking at what we do, “How do you justify a cooking group?” and we can talk about that in regards to living skills, in regards to socialisation, to normal activity, in regards to meaningful activity for people. But we can't produce a paper that says this is why we do the things we do...that make it difficult to prove what we are doing and why. It's almost seen as secondary and diversional at times (Bronwyn – int¹).

This lack of evidence for occupational therapy interventions had often reduced her confidence and made the situation seem worse. While Bronwyn knew from her practice experiences that specific interventions were clinically efficacious, but without evidence, they were not given the same weight within her team as the empirical research which psychologists were able to locate to support their psychological therapies.

Bronwyn experienced this first position as a series of contradictions and confrontations. Her confidence in the use of occupation and in her undergraduate program was still strong but she felt ‘under a barrage’ of external knowledge needs. She also felt unprepared for the ‘barrage’ of pressure from managers and colleagues to acquire generic mental health skills based on knowledge about how to handle clients expressing suicidal

Chapter 6: Findings—Developing Personal Paradigms and Theoretical Knowledge Use in Mental Health Practice

ideation, risk management, and medications that were not covered in her occupational therapy education. This further eroded her confidence.

Her greatest challenge came two years later when she moved to a regional community mental health team. This relocation and reorientation was into an acute community mental health team and was significant, as no occupational therapy role had been established. At this local service level, practice was a direct translation of mental health legislation and policies, which often directed the focus of practice at biomedical rather than occupational issues. Bronwyn explained:

In that more generic role, the way I formulated treatment plans in my head was always as an OT...but how do you apply new meaningful activities to someone being forced to have a depot injection (Bronwyn—int¹).

Despite these issues, Bronwyn fought to have occupational therapy accepted as a component of this mental health team. Her position in this team, combined with the distance from other occupational therapists, resulted in her experiencing professional isolation. In her new environment, Bronwyn missed the benefits of support from senior colleagues. In this new post, her closest occupational therapy colleague was over 100km away. In this sole practitioner role, she was expected to develop and sustain her professional identity when it was a constant battle to have her occupational therapy skills recognised by more biomedically orientated colleagues. There was also pressure from the other team members to provide psychological interventions based on Dialectical Behavioural Therapy (Linehan et al. 1999) and Cognitive Behaviour Therapy (Beck 1976) based counselling.

These dilemmas were reflected in Bronwyn's choices of continuing professional education. Although she had qualified in 1999, Bronwyn acknowledged her main source of occupation-focused theoretical knowledge remained her initial professional education. She was concerned

Chapter 6: Findings—Developing Personal Paradigms and Theoretical Knowledge Use in Mental Health Practice

this meant she was losing contemporary theoretical knowledge. Although Bronwyn was aware of this, she continued to prioritise continuing professional education and book purchases focused on improving practice skills and techniques. This continuing education was largely focused on therapies derived from psychological frames of reference. Courses in these psychological therapies were available and Bronwyn considered they added value to her role; they were also funded by her employer, which was supportive of training its staff. It was Bronwyn's choice to prioritise these over occupation-based courses, which did not seem to add value or assist her in her career moves.

An intense period of battles led to a change in professional resilience for Bronwyn. She constantly dealt with colleagues questioning her professional occupational knowledge. Even other occupational therapists in the area who worked outside of mental health practice questioned her role. She found this questioning from other occupational therapists more dispiriting than that from the colleagues on her team. Her in-team battles often involved a fight to widen the job criteria so occupational therapists could fill vacant positions. What sustained Bronwyn's professional resilience was the value she placed on occupation and her professional skills in providing occupational services. This belief in the value of occupation in therapy had remained constant. As she described:

I'm supervising people who are struggling with the same things
I struggled with and trying to be clearer about the OT role and
what is being an OT within a team (Bronwyn—int¹).

The pressure on the team was to deal with acutely unwell people who often needed admission to hospital by their case managers. The responsibility for service users was thus placed on the individual case manager. When caseload numbers were high, the level of support from colleagues in these community teams was often dissolved. In addition to these pressures, for Bronwyn, setting up this new role meant patiently and endlessly

Chapter 6: Findings—Developing Personal Paradigms and Theoretical Knowledge Use in Mental Health Practice

explaining what occupational therapy was to service users and colleagues, which proved increasingly frustrating.

Bronwyn's story illustrated how the power of one person's beliefs can change perceptions of the occupational therapy profession. Her minority professional status as a sole occupational therapist within community mental health services led to Bronwyn feeling she was the public face of the whole profession. This was daunting. Bronwyn knew the previous occupational therapist, who had worked in other mental health services in the local area, had left a poor perception on other disciplines. After three years, Bronwyn felt she had made a small dint in expanding the occupational therapy role in this community team. However, on examination for this research, she realised she had achieved an increased profile for occupational therapy in that setting.

When being continually confronted with others' questioning of her professional identity in this role, she felt she needed to consider 'How am I an OT?' Her professional supervision had been based on teamwork issues, but on reflection, Bronwyn felt what she had needed at that time was supervision, which focused on her cases and how to initiate occupation-based therapy.

Her geographical isolation from other occupational therapists meant she sought and gained support through informal and formal networks available in a local city, attendance at monthly meetings with all the occupational therapy mental health staff followed by a social night. This was an opportunity to have her 'OTness' reinforced. These meetings, while supportive, sometimes made her question her professional identity and made Bronwyn feel she was 'not OT enough' (int¹)— an experience of not being able to use what she valued in her practice. This led her to move to two new part-time jobs where she again had to create new roles, as an occupational therapist working in a mental health private practice, and in a

Chapter 6: Findings—Developing Personal Paradigms and Theoretical Knowledge Use in Mental Health Practice

mental health service for adolescents. She likened this process to ‘really having to forge these roles out of unwilling metal’ (int¹). There was a feeling of having to prove her professional knowledge could be valued in these situations—and to justify why she was employed instead of a psychologist or a nurse.

Working in private practice, and her role as a supervisor for new staff members, reinforced the need for more evidence-based practice. However she found that ‘we can’t produce a paper that says this is why we do the things the way we do’. Throughout her professional journey, Bronwyn relied on her occupational therapy core knowledge of activity analysis, which was ‘painful at Uni – but useful in practice’, and on group work theories, and philosophical ideas about the meaning of occupation. Her use of theoretical knowledge was based on her belief that:

You don’t have the one thing for one person. No one model is going to completely work perfectly in my mind and encapsulate everything I understand about OT. But at the moment the Model of Human Occupation that’s kind of ticking over in my head (Bronwyn—int¹).

After the first interview the focus of her career moved from her two part-time jobs in child and adolescent services and private practice to a full-time senior occupational therapy management position within the public health system. In this role, the research interviews had made her rethink her use of psychological frames of reference based on reflections of ownership and how occupational therapists used these models. Her supervision of other staff had sharpened her need to do this. She was aware the focus of occupational therapy could be removed from practical occupation-based work which she described as ‘an absence of doing’. She found her supervision of other occupational therapists along with the use of a recovery approach, had required a change in her own practice theory/framework. This led to a subsequent change in practice.

Chapter 6: Findings—Developing Personal Paradigms and Theoretical Knowledge Use in Mental Health Practice

Bronwyn learnt from her experiences and in her new senior role she recognised newer graduates were also under the same pressures to change their practice—they were ‘under a barrage of suggestions about what they should be doing’. She used her previous experience of professional socialisation to provide support for others. This resulted in four new occupational therapy positions in mental health settings in the regional area. The socialisation that had supported Bronwyn was duplicated in her plans to start occupational therapy meetings in the local area, which aimed to provide an opportunity to share information with her peer group. This decision demonstrates the value Bronwyn placed on her previous professional socialisation and the benefits of sharing her experiences and personal knowledge about how to deal with the challenges inherent in working in mental health practice.

The following story represents the participants who held a strong belief in the efficacy of occupationally focused theoretical knowledge and occupation-based practice.

Alex’s story – Consolidating Professional Ideologies and Identity

Unlike Diana and Bronwyn, family members had suggested Alex’s entry into the profession. His aunt, who worked with other occupational therapists, recognised a match between his academic achievements and his talent for practical activities. During his entry-level program Alex had felt an affinity with mental health occupational therapy practice. This affinity was reinforced during his placements when he described that he had immediately felt ‘at home’. Alex’s first appointment in mental health services had been in an acute inpatient mental health unit. From there he moved into rehabilitation, first in the community, and then within a larger hospital based program. At the time of the interviews he had moved back into the fast pace of acute inpatient work.

Chapter 6: Findings—Developing Personal Paradigms and Theoretical Knowledge Use in Mental Health Practice

This move back into the acute psychiatric services saw Alex as the senior occupational therapist providing leadership to a small team. He worked in an intensive care psychiatric inpatient unit where service-user stays were very short—one to two days being the average. In this environment, Alex used the Model of Human Occupation [MOHO] tacitly to focus on connecting service-users to their previous routines and habits through the use of activity. Alex used activity as a transaction, as a symbolic mechanism for occupational engagement, as a means of achieving engagement ‘in the moment’.

Alex had remained occupation-focused throughout his career. He applied his valued occupational therapy knowledge to new roles. This had been easier in rehabilitation settings where his tacit use of MOHO had led him to focus programs on engagement through volition, and organising the routines and increasing roles of service-users. In community-based settings he conceptualised service-users’ occupational issues using theoretical knowledge from the MOHO, but his practical actions were focused on building service-users’ living skills, which were the service’s focus.

Throughout his career, Alex had experienced some difficulties establishing his role with colleagues, throughout his narrative he reframed these difficulties as challenges. Alex demonstrated he had the capacity to frame these challenges positively and maintain a strong professional identity. In his first job in an acute mental health setting, he had faced the same challenges previously described in Bronwyn’s story. Nevertheless, when Alex described this experience he recalled the challenges he had overcome. He considered work in acute inpatient units as a vital learning curve because the team of occupational therapists he worked with provided professional socialisation and modelling before he moved to a community team where he was professionally isolated. Alex’s first job, with its professional socialisation and support structures, had anchored him to occupation-based practice. His experiences had also reinforced the

Chapter 6: Findings—Developing Personal Paradigms and Theoretical Knowledge Use in Mental Health Practice

therapeutic usefulness of occupation for service users. His focus on the service user, not on what others thought of him or his role, allowed him to maintain professional integrity throughout his career.

Alex had never felt the need to use psychological frames of reference in practice. He relied on his occupational therapy professional and theoretical knowledge domains gained at university to guide his practice, which was focused on service-users' occupational issues. He based his interventions on engagement in practical task-based activities, which allowed participation. The positions he worked in had allowed this approach to flourish and he had avoided working in an acute service community mental health team as he realised the difficulties of combining his style of occupation-based work with acute case management.

At each career stage, Alex had used the MOHO but only at a tacit, conceptual level. The reflection afforded by this research process led to Alex's description of cases when he had used volition and other concepts from the MOHO. His interventions were focused on these aspects of the model. He then translated these aspects into his use of activity. This directed his practice. He saw occupation as a means of achieving therapeutic engagement and relationships. He valued his input, as did his service users and the majority of his colleagues. His experiences were largely in departments where he could work alongside other occupational therapy colleagues. This way of working translated across services from inpatient rehabilitation, community rehabilitation and acute inpatient settings.

On reflection, Alex felt the professional socialisation in mini-occupational therapy communities had helped him sustain his focus on occupation-based practice rather than being drawn towards therapies from psychological frames of reference. He expressed concern with his current service, as the new graduates were more isolated and unable to gain the

Chapter 6: Findings—Developing Personal Paradigms and Theoretical Knowledge Use in Mental Health Practice

benefits of role modelling. Opportunities for informal discussion were limited and new graduates relied on formal supervision for support. His reflection was that his personal and professional experience of using occupation to cope with stress or learn new skills, helped him overcome, or to live with, a lack of a framework, and 'to sit with being flexible'. He was able to live with the ambiguity of the use of occupation in his practice.

These three stories reflected the participants' differing personal paradigms (Björklund 1999; Törnebohm 1991), and how these paradigms had both directed their career paths and consequently, the different forms of theoretical knowledge they applied in practice. The following section is a discussion of how different episodes in the participants' careers impacted on their personal paradigms

Episodes in Professional Histories

The following episodes emerged from the cross-sectional coding and are assembled in chronological order.

Pre-entry level stories: Influences on the value placed on occupationally-oriented theoretical knowledge

The participants' positive identification with an occupational perspective of health often began prior to their formal entry-level programs. Three of the nine participants had chosen a career or degree in occupational therapy because family or friends had identified their affinity with occupation and had suggested the profession to them (Eliza, Alex, and Anna). Four others had made their selection because of the connection to the concepts and philosophy of the profession (Liam, Anna, Bronwyn, and Sarah) while two participants had chosen it randomly (Maria and Diana). Despite the range of pathways leading to careers in occupational therapy, the participant's validation of occupation in their life, or the lives of others, were important factors in sustaining their professional identity.

Entry-level program: Valued theoretical knowledge

The participants' comments illustrated the ways in which occupation-focused curricula from the professional entry-level programs influenced the choice of, and use of, an occupation-focused model. This influence continued throughout their professional journey—no matter how long since their graduation. This was because all were more comfortable with the occupation-focused theoretical knowledge learnt at university. It seemed this familiarity and comfort with an occupation-focused model had led to its early use as tacit knowledge. Megan suggested:

When I was at Uni, the practice model that drove the course was the Occupational Performance Model (Australia). It drove the course and was entrenched in everything we did. This is the model that I took on. I'm interested in other models because I felt that I missed out on learning about MOHO and some of the other really big models. I find I don't get my head around MOHO as easily as I'd like to because it wasn't part of the Uni course (Megan—int¹).

Sarah described how the value and subsequent use of an occupation-focused model was influenced by familiarity gained during her initial occupational therapy education. She said:

It's not that I'm not open to new information and new knowledge. I just find that ... and maybe it's because you do all your assignments in that and everything you do is in that, so you just become practised in working in that [occupation-focused model] framework (Sarah—int¹).

Alex (int¹) also noted during his entry-level program: 'It was mainly Kielhofner [MOHO] that was pushed when we went through. It was like our bible'.

Time spent in entry-level programs provided opportunities to learn about occupation-focused models and become familiar and comfortable with them. Participants applied occupation-focused models in assignments and classroom discussions. They also learnt from discussions with fellow

Chapter 6: Findings—Developing Personal Paradigms and Theoretical Knowledge Use in Mental Health Practice

students, and lecturers discussed their own experiences of the clinical utility of these in practice. Once they had graduated from their entry-level program, participants continued to use the version of the model taught at university because of their familiarity in applying it to case scenarios and assignments. Liam (int¹) noted it was important the connection with practice was made clear, as, in discussing why he enjoyed learning about the MOHO he stated: 'I like big picture ideas but only as long as they have some relevance and can be applied in a practical way'.

While participants were aware of newer versions of occupation-focused models, they found these early habits difficult to change. Bronwyn noted:

I guess in my mind I go back to the Model of Human Occupation that I learnt when I was at Uni... I guess it's out-dated, while it has changed several times since then it's been the underpinning theory in my mind. It is an out-dated model but that's what I used at Uni and that's what's in my head now (Bronwyn—int¹).

When participants were exposed to more than one occupation-focused model during their professional entry-level program, they chose one with concepts and constructs which best matched their personal view of occupation. Anna noted:

The MOHO suited my way of thinking because it offered more structure and detail than other occupation-focused models'. Maybe it was how it breaks down each of the facets. There was something about it that just made a bit more sense. It just seemed to hold more detail and I felt as though it fitted in mental health better (Anna—int²).

Having established the ways in which undergraduate programs shape valuing and use of occupation-focused models the following section describes how this was influenced by graduates' the transition into their first career positions.

First jobs career stage: Professional identity and action

For eight of the participants in this study, the transition into the workplace had included work in acute psychiatric inpatient units within their first two years of practice. In this study, the participants all perceived some jobs in mental health practice, particularly those in acute inpatient settings, were for new graduates. Despite this perception, participants did not regard acute inpatient units as supportive environments. While Alex, Diana and Maria enjoyed working in these environments, the six other participants did not. This dissatisfaction led to limited time spent in these acute psychiatric inpatient units, ranging from 6 to 18 months. Participants usually left this type of workplace as soon as an alternative position in community-based mental health teams became available. Maria noted:

I have lots of new grads who come through [the acute inpatient unit] and they might last twelve months to two years, but they move ... they see it as a stepping-stone because in this position it's the intensity of the medical model. In the community teams they have not got to fear the medical model to the same extent as on a daily basis here (Maria—int²).

The first job career stage was described as a time of transition from entry-level programs, with strong occupation orientations, into workplaces dominated by biomedical discourses. On leaving university, Sarah (int¹) remembered her transition into the workplace had felt as though she was in: 'Another world with a new language'.

Even though these events had often occurred years earlier, during their early career stage, participants used metaphors of 'war' and 'battle' to describe the challenge of implementing occupation-based practice in these acute psychiatric inpatient units. These metaphors reflected the challenges of working with the dominance of biomedical discourses. While other participants did not enjoy the experience, Alex, saw it as providing good learning experiences. However, he even acknowledged, on reflection, it had been a 'trial by fire' (Alex—int²).

Chapter 6: Findings—Developing Personal Paradigms and Theoretical Knowledge Use in Mental Health Practice

One component of these battles was the difficulty in dealing with the hegemony of biomedical discourses in describing service-user issues and the pressure to adopt psychological frames of reference. Participants noted discussing effective therapies often led to team members extolling the efficacy of psychological theories and therapies, which left participants feeling their occupational therapy knowledge was dismissed as inadequate. Again, participants used the metaphors of war associated with the challenges they needed to negotiate the dominant discourses. Invariably, the mental health setting's service-delivery methods were oriented around biomedical interventions with the focus on symptom reduction. This orientation challenged participants' occupational perspective.

In addition to these pressures, managers required participants to acquire generic mental health skills. This often led to training courses on risk assessment, and expectations they would work in generic roles. Although they appreciated the new knowledge, there was pressure to learn this knowledge and use these generic skills outside of their professional domain. This led to stress, which affected their confidence.

Alex provided an example of assertive strategies to live with the tensions in this environment. Rather than adopting a combative stance and feeling defeated by this situation, Alex had accepted that in the acute, inpatient setting, occupational therapists needed to apply their knowledge of biomedical information, as it supported effective treatment in this context. One of the supportive factors in learning to live with, and not becoming submerged by this discourse, was the professional socialisation and role models available to him. He expressed concern for others who did not have access to these supports.

During this career stage, participants perceived there was pressure from all sides, within the profession and from colleagues, to expand their skills 'outside of occupational therapy'. The transition into practice involved a

Chapter 6: Findings—Developing Personal Paradigms and Theoretical Knowledge Use in Mental Health Practice

‘barrage of new knowledge’ and a ‘struggle’ to survive under the pressure felt when their employer or colleagues expected participants to know skills outside of occupational therapy’s professional domain. Liam said:

Something I went through when I was first starting out as an OT – you finish Uni, start working and then have the opportunity to do training. Often in mental health positions you’ll think, ‘Oh I need to get trained in CBT or ACT,’ or some of these formal things, but you also need to think, ‘Oh well maybe I need to develop some skills around more OT specific areas,’ And it’s a balance because you use, you need to be aware of the different approaches and you can get lots of things to put in your toolbox from doing some of those other, from studying some of those other approaches or therapies or whatever but I think it’s important for us to retain our own identity and approach (Liam – int²).

One protective factor was that while participants felt ‘bombarded’ with medical and generic mental health knowledge, they recognised this acute setting had allowed them to consolidate important generic skills. Megan noted:

The information that I was trying to learn and get my head around was kind of really from that and the medications, the symptoms, how people get diagnosed, the Health Act, those practical things that were happening in the workplace there (Megan—int¹).

In acute inpatient units it was hard to get validation from colleagues for occupation-based therapies, with the constant frustration of explaining the intrinsic and extrinsic goals of treatment to others, proving to be very frustrating. While many participants ‘remained strong’, there was a sense they were being ‘squashed’ by the biomedical orientation, and pressure to adopt psychological therapies.

The pressures in this acute environment were created also by the perception of reduced time for occupational interventions. Participants described how the fast pace of the environment and high turnover left little time for engagement with service users. This could result in reduced job

Chapter 6: Findings—Developing Personal Paradigms and Theoretical Knowledge Use in Mental Health Practice

satisfaction. As new graduates with little experience of these conditions, many found it difficult to deal assertively with interruptions to their practice. Continual experiences of negative validation of occupational therapy skills, and a pressure to rapidly develop generic mental health skills, forced new graduates to comply with these interruptions whilst experiencing the underpinning frustration. To preserve self and professional identity, these constant battles created the perceived need to develop some of these skills and to leave the position as soon as possible.

Ideal jobs: Finding the right match

An ideal job was characterised by participants as involving both a match between the participant's opportunities to use valued occupation-focused theoretical knowledge in practice and the receipt of external validation for its use from colleagues. Within each participant's professional history there was a conscious or unconscious desire to find the right match between valued and used theoretical knowledge. The research interviews allowed time for participants to reflect on these decisions. My analysis of their professional stories highlighted how desire for the right match had underpinned many of their decisions, as all stayed in jobs which offered opportunities to use valued theoretical knowledge to guide occupation-based practice. This had led to participants staying in their ideal jobs for over two years. Prior to these reflections, participants had often felt disheartened and blamed themselves for leaving jobs where they had poor experiences. Through reflection in this study each participant realised these experiences had been context driven. For the majority of participants, the decisions to move from certain contexts usually depended on whether the mesoenvironments and macroenvironments were conducive to the use of occupation-focused models, and occupation-based practice.

Chapter 6: Findings—Developing Personal Paradigms and Theoretical Knowledge Use in Mental Health Practice

Each of the participants had worked hard to find the ‘right match’ between the occupation-focused theoretical knowledge they valued and what they could use in practice. These moves were unique to the person and were often unconscious. They were often connected to participants’ valuing of different forms of knowledge. The spectrum of value placed on occupation-focused models of practice was presented in Figure 5.2. As noted in Chapter 5, I initially used this diagram as a visual cue when I asked participants to rate where their current job lay on, what I term, ‘the value-use spectrum’. This was used in the interviews as a visual representation of the equilibrium of valued and used theoretical knowledge, to encourage discussion on this finding. Each episode and new job could act as a nexus of change moving the balance to, or from, the value or use of occupation-focused models and occupation-based practice. An ideal job was identified when it met a participant’s personal needs and cohered with valued knowledge.

Participants remained in jobs when they had the opportunity to practise their valued theoretical knowledge. For eight of the participants this was occupation-focused theoretical knowledge, but for Diana, this meant staying in a position where her primary source of theoretical knowledge was the biomedical model. Participants stayed in these ideal jobs if those jobs met their needs on the value-use spectrum (as illustrated in Figure 5.2). Hence, the participants with over 10 years’ experience had been in their current post from 3-20 years.

The process of finding the right match between the value and use of different forms of theoretical knowledge involved the following factors:

- Moving jobs developed experiential knowledge and strategies to maintain professional identity and professional resilience.

Chapter 6: Findings—Developing Personal Paradigms and Theoretical Knowledge Use in Mental Health Practice

- Varying and increasing the use of valued theoretical knowledge in a job when possible.
- Fitting in with teams and services, and achieving validation, for the role and integration of occupation-focused models.
- Removing self from intolerable workplace environments to protect professional identity and to maintain professional resilience.
- Finding a ‘good’ job – the right match between valued and used theoretical and professional knowledge.

All the participants remarked on the importance throughout their professional journey of leaving stressful workplaces. Although the definitions of what made workplaces stressful were different for each participant, a common theme existed. These were workplaces where colleagues or managers did not validate and support a participant’s use of occupation-focused theoretical knowledge and subsequent practical actions. For Anna and Sarah, this dissonance was experienced because their service required them to use the specific therapies of psychotherapy, and Attachment Theory drawn from psychological theories. Some psychology colleagues frowned upon occupational therapists using these therapies because they considered their use should only be within psychology’s professional domain. In her workplace, Diana experienced stress because she preferred generic work and did not welcome the demands of her manager to do more occupation-based practice.

The need to move jobs occurred when participants realised the mesosystem within a service and its orientation did not allow for a match between the theoretical knowledge he or she valued and possibilities to use this in practice. For the majority of participants this often involved a participant’s need for more engagement in occupation-based practice. This led to the professional journeying with frequent moves between jobs.

Chapter 6: Findings—Developing Personal Paradigms and Theoretical Knowledge Use in Mental Health Practice

Each participant viewed the frequent moves between jobs throughout their careers as a positive experience. These moves had allowed them to find a more suitable job with experiences which expanded their personal knowledge domains. These moves had allowed participants to remain within the mental health workforce and the occupational therapy profession. While the recruitment and retention of occupational therapists has been reported as problematic in the literature, participants considered career mobility a social norm for occupational therapists. Sarah stated: 'It is normal for occupational therapists to move around a lot' (int²).

Section 2: Developing a 'Professional Toolbox'- The Integration of Different Forms of Theoretical Knowledge in Participants' Mental Health Practice

Section 2 of Chapter 6 focuses on the participants' integration of occupation-focused models and psychological frames of reference, into practice. It also presents the varieties of interplay between the theoretical and professional practice knowledge domains. It reports on findings about the integration of different forms of theoretical knowledge in practice, as follows:

- The use of occupation-focused models remained constant over time with participants drawing on one occupation-focused model – whereas the use of frames of reference, drawn from psychology, was dynamic and driven by context or type of service, or influenced by trends.
- The participants' use of frames of reference was primarily focused on their instrumental use – from techniques and skills.

Occupation-focused models:

Chapter 6: Findings—Developing Personal Paradigms and Theoretical Knowledge Use in Mental Health Practice

- Were used explicitly for describing practice to others, and also during reflection on practice
- Were most often used by practitioners in the tacit dimension of practice
- Were used as conceptual guides to appraise and analyse a person's occupational issues. Their use led to the forming of an explicit plan of action based on principles from the model. This plan could be implemented using group work, or therapeutic use of occupation and other professional knowledge domain techniques from occupational therapy. However, the plan frequently drew on factual knowledge, or therapy techniques drawn from a psychological frame of reference
- Shaped professional identity and reasoning
- Were used in different ways combined with the professional knowledge domain but were most commonly used in tandem with psychological theories and
- Provided a vocabulary enhancing reasoning and assisted in explanation of occupational therapy to others.

Seven participants considered the use of frames of reference drawn from psychological theories to be important in practice. The use in practice of frames of reference drawn from psychological theories:

- Contributed to the development of a professional toolbox
- Often led to practical actions and interventions, which were targeted at specific psychological performance components rather than service-users' occupational issues
- When used explicitly and instrumentally created a potential loss of balance, towards a performance component driven approach. This led to a loss of occupational-focus when combined with the conceptual use of occupation-focused models; and

Chapter 6: Findings—Developing Personal Paradigms and Theoretical Knowledge Use in Mental Health Practice

- Often resulted in clinic-based ‘talking therapy’ rather than dealing with the occupational issues through participation, or practice of the actual occupation in the community. This led to therapy described by participants as more ‘talking and less doing’, ‘losing the balance,’ and as ‘an absence of doing’ and
- Were influenced by the sociocultural perspective within workplaces.
- Were influenced by other sociocultural pressures to adopt these psychological frames of reference by other occupational therapists within the participants’ communities of practice.

Participants were asked to reflect upon their use of occupation-focused models and psychological frames of reference. The participants’ use of different forms of theoretical knowledge is summarised in Table 6.3 below. In this Table, I have used the term ‘explicit’ to describe the main way in which frames of reference were used to underpin therapy, and techniques used in treatment interventions. Seven participants who identified using frames of reference were easily able to articulate and identify how they were used. However, for the other participants psychological frames of reference were used in tandem with occupation-focused models. These combined with the participants’ professional knowledge and formed their professional toolbox.

Chapter 6: Findings—Developing Personal Paradigms and Theoretical Knowledge Use in Mental Health Practice

Table 6.3: Participants’ use of different forms of theoretical knowledge

Pseudonym	Occupation-focused models	Use in practice	Explicit use of frames of reference
Alex	MOHO	Tacit	None
Anna	MOHO	Tacit	Acceptance and Commitment Therapy (ACT), Dialectical Behavioural Therapy (DBT) and Narrative Therapy
Bronwyn	Kawa, MOHO	Tacit	Brief solution-focused therapy (BSFT)
Diana	MOHO	Tacit	Cognitive Behavioural Therapy (CBT)
Eliza	MOHO	Tacit	None
Liam	MOHO	Tacit, explicit when in supervision	ACT, BSFT
Maria	Mosey’ ontogenesis, MOHO	Tacit	DBT
Megan	OPM (Australia)	Tacit	BSFT
Sarah	OPM (Australia)	Explicit	Attachment theory

The participants’ use of different forms of theoretical knowledge impacted on explanations of practice, and consequent practical actions. These impacts are summarised in Figure 6.2 below. This Figure summarises the implications on practice, of using different forms of theoretical knowledge and the professional knowledge domain. These implications are described more fully below.

Chapter 6: Findings—Developing Personal Paradigms and Theoretical Knowledge Use in Mental Health Practice

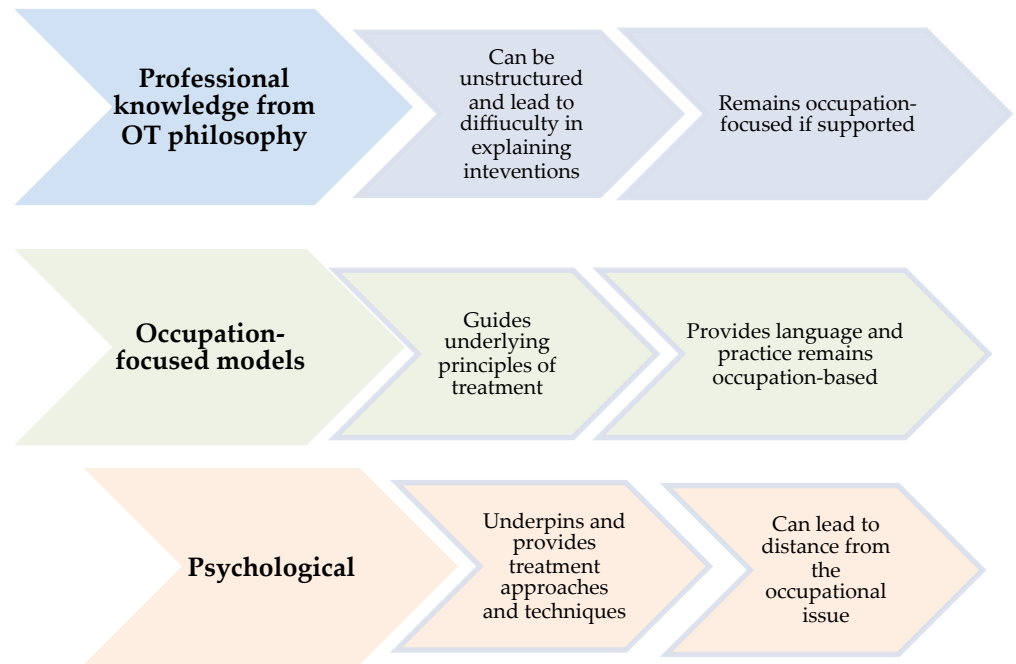


Figure 6.2: Different forms of theoretical knowledge use, and implications in practice (Ashby 2011a)

A discussion of the professional knowledge domain is included in this section, because skills and knowledge were used to guide and develop participants' practical actions. It was this professional knowledge that guided the use of professional skills in using occupation as a therapeutic modality. These practical actions were also influenced by participants' previous experiences and drew on their professional philosophy, or paradigm. In this situation, these skills were underpinned by philosophical assumptions about the importance of engaging in occupations for wellness rather than other forms of theoretical knowledge.

Use of Professional Knowledge Domain

As noted earlier in this chapter, the participants' experiences during their entry-level program and its curriculum content shaped the occupation-focused theoretical knowledge, which they valued and used. Much of this was derived from the professional knowledge domain. From this domain, participants drew upon the principles and assumptions which underpin occupational therapy practice. Eight of the participants described their

Chapter 6: Findings—Developing Personal Paradigms and Theoretical Knowledge Use in Mental Health Practice

central belief in the efficacy of occupation, as it underpins wellbeing. Participants described how they used knowledge from this domain using examples from different case scenarios. Alex, Eliza, Liam and Maria felt this central belief in occupation was what they relied on more than any other form of theoretical knowledge.

The participants' implementation of interventions involved drawing on occupational therapy's professional knowledge domain. This was made more visible through reflection and professional supervision. It involved the therapeutic use of occupation, and the use of an occupational perspective. The participants' professional knowledge was affected by their entry-level program's curriculum, other occupational therapists, and practice experiences. It was the unchallenged knowledge, in what Wenger, McDermott and Snyder (2002) referred to as the wider community of practice. In this study only Diana questioned its efficacy. The efficacy of knowledge from this domain was often unproven in research, and difficult to describe to colleagues, but was accepted uncritically by participants due to personal experiences of its effectiveness, i.e., practice-based evidence. Additionally, in the first interviews, when participants were asked about their use of theoretical knowledge, eight of the nine commented their interventions were not based on any underpinning principles from occupation-focused models. Participants suggested the clinical efficacy for interventions was only derived from their professional knowledge domain. In effect, analysis showed that the occupational therapy professional knowledge domain served as a link between theory and practice and guided practice directions.

My analysis revealed how participants described the professional skills derived from the professional knowledge domain, and their translation into daily practice. These skills were often the practical, techne-rational skills learnt during university studies, or 'the how to' skills which came directly from learning from others. Much of this was absorbed from

Chapter 6: Findings—Developing Personal Paradigms and Theoretical Knowledge Use in Mental Health Practice

experiences on clinical placement. Those skills learnt at university included group work, and activity analysis. Participants learnt their core skills at university and consolidated them in practice as demanded by the practice context. The core skills described by Liam and others are in Table 6.4. While learning from others worked well if an occupational therapist had occupational therapy colleagues, it was less effective for Diana who had largely worked as the sole occupational therapist in a multidisciplinary team.

Table 6.4 Examples of knowledge from the professional knowledge domain

Knowledge from the professional knowledge domain
Activity scheduling and putting structure into the service-users' day to assist with sleep routines.
Group work and leadership skills.
Valuing ordinary everyday activities – living skills, such as shopping, banking/ budgeting, cooking.
Importance of engagement and participation in social dimensions of health. Social events – BBQs, exercise walks.

Occupation-Focused Models Shape Professional Identity and Reasoning

The ways in which participants used occupation-focused models revealed a more multilayered approach to their integration in practice. All the participants used an occupation-focused model in some form in their practice which ranged from tacit to explicit. The participants' explicit use of occupation-focused models was primarily in the design and use of assessment tools derived from an occupation-focused model. Nevertheless, participants mostly used occupation-focused models tacitly to understand service-users' occupational issues, and plan interventions based on service-users' identified occupational needs. All the participants' use of occupation-focused models in practice reflected the personal preferences

Chapter 6: Findings—Developing Personal Paradigms and Theoretical Knowledge Use in Mental Health Practice

initiated at university. The use of occupation-focused models varied as shown in Table 6.5.

Table 6.5: Use of occupation-focused knowledge in practice

Use of occupation-focused model	In practice
Explicit	Occupation-focused theoretical knowledge has a direct impact on practical actions observable by others. It is a foundation for practical actions at all levels of professional reasoning. The occupation-focused model acts as a framework for interviews, assessments and interventions, at all levels of professional reasoning. The participants' use in theory and practice is articulated.
Tacit	Occupation-focused models guide the practical actions of the occupational therapist but the theory-practice nexus is unarticulated to others. The model underpins the overall direction of therapeutic interventions. While it supports practical actions this is not articulated at any level of professional reasoning unless participants reflected on practices, as in this research.

Liam and Sarah described their explicit use of occupation-focused models. Liam was aware his explicit use of theoretical models was primarily due to the thinking and reflection required, and directed by his supervisor. Interestingly, even with his reported reflection, when first asked about his use of different forms of theoretical knowledge, he responded as follows:

In all honesty, I can't think of any models or formal theory things that really jump out at me. But, sometimes, and particularly, in supervision when I talk about a problem I'm having with a particular client or if I'm stuck with a group or something like that I use some of the language of [MOHO]... I think about this person's roles, or their habituation, or where their motivation and volition comes from. Those sorts of things come out. Or, I obviously use the language of the Canadian Model, which is something I use to break things down into the person-environment and occupation.

It's often my supervisor who highlights, 'well you're kind of talking about this'. She pushes me to use theoretical grounding that I'm probably using subconsciously, but not in an overt way. So, I'm probably not using it in the most effective way,

Chapter 6: Findings—Developing Personal Paradigms and Theoretical Knowledge Use in Mental Health Practice

which is why I get so much from supervision. Because she's more comfortable with that [model] (Liam int¹).

During the assessment phase of interventions with service-users, occupation-focused models provided participants with frameworks and explanations from which to explore and analyse service-users' occupational issues and form a response to resolve these issues. For example, those who used MOHO applied concepts from the model to frame interventions increasing service-users' participation in chosen occupations, roles, or routines. However, while Megan conceptually used the Occupational Performance Model [Australia] (OPM-Aus) (Chapparo & Ranka 1997) only Sarah had explicitly used it to design an assessment tool. Sarah used language from the OPM-Aus to frame her practice and describe her assessment process to others. The language from the OPM-Aus also assisted her when explaining her role to others. This occupation-focused theoretical knowledge was central in guiding her occupational therapy process. Sarah described her use of the OPM-Aus:

It's good to have a model, or a structure, to hang everything from. If you've got some structure behind you, you go, "okay, that's the framework in which I'm working from" ... It provides a framework for when I'm assessing a client ... it informs what I do in terms of what I'm looking for. And what issues, and what areas I'm looking for them in (Sarah—int¹).

The next section describes the participants' tacit use of occupation-focused models.

Tacit Use of Occupation-Focused Models

At the beginning of the interviews, participants often stated they did not practice using any formal theory. As noted in subsequent discussions, I found occupation-focused models were used tacitly. Polanyi (1966) stated the use of different domains of knowledge becomes tacit when we 'know more than we can say' (p.7). The majority of participants had moved from

Chapter 6: Findings—Developing Personal Paradigms and Theoretical Knowledge Use in Mental Health Practice

explicit to tacit use of occupation-focused models quite early in their careers as they became embedded in participants' thinking. Hence, they had to think hard to describe exactly what that involved. Participants generally found the concepts from these models useful to describe their practice.

In Megan's practice, her use of the OPM-Aus (Chapparo & Ranka 1997) was tacit. The model's clinical utility was due to its clear constructs leading her to consider the implications of service-users' environments, and the impact of these on participation. She described her rationale for using this model:

You can't change the environment without changing what's happening to the person and you can't change a person without changing the environment. I really felt, from my experience, I really felt that was true (Megan – int²).

The successive interviews created time and space for reflection and some participants' referred to revelations as 'light bulb moments' when describing what had formerly been tacit use of occupation-focused models. For example, Eliza initially stated that although she had become very familiar with the MOHO during her education she did not integrate it into her practice. She had not felt she used any specific occupation-focused model, either conceptually or instrumentally, to direct her practice actions. In the first interview, Eliza primarily connected her occupation-based practice with the practical skills within her professional and factual knowledge domains. She felt these domains guided how to design and conduct occupational therapy programs. However, during the first interview, it became clear the MOHO had also influenced her conceptualisation and design of occupational therapy programs throughout her career. The MOHO had also provided her with the language she used to describe rationales for interventions, to her colleagues. This language moved her from describing activities and groups used in the program, to describing the theory underpinning their use. Until

Chapter 6: Findings—Developing Personal Paradigms and Theoretical Knowledge Use in Mental Health Practice

the first research interview, with time to reflect on practice, this use of the MOHO had remained tacit. Even though the use of psychological therapies in her service was adhered to, Anna described how she used the MOHO to provide a lens to consider the impact of anorexia nervosa:

With something like anorexia nervosa, it's not rehabilitation, but habilitation because it's almost like the, world they previously knew has been erased. It's how they can actually build themselves a life and an identity outside of that illness and the difficulty in trying to tap into it. Almost redevelop interests, redevelop in a sense or either develop or get in touch with their volition a sense of what really does drive them within the world, what they value and what does it inherently mean to them and what structures can be put in place and routines can be put in place that can actually support that. And, what roles they actually need to bring on board to actually develop that sense of identity and through those roles often get a clearer sense of what their values are given that they're so disconnected from (Anna—int²).

Alex also described how he used the professional domain knowledge of occupation to guide his daily practical interventions with service users. However, he suggested that:

It's not something I probably formally think about, but then having said that I often sit in ward rounds and go back through it [MOHO] – what are they interested in, where do they live, who do they live with, what do they do when they're not here in hospital? I guess I still use all those little mental prompts.

This morning with the clients I brought the newspapers onto the ward and sat down. I pretended to flick through the newspaper and started an informal conversation by asking, 'When you're not in hospital what would you normally be doing on a Tuesday morning?' – getting those same conversations going. I guess the prompts in my head are still probably following that model [in relation to volition and habituation]. And I'm looking for the hook. What are they interested in first so I can build a little bridge with whatever tidbit of information they give me. 'I'd normally be at Uni'. Or 'I'd be just getting the kids off to school'. I think it still goes back to the Model of Human Occupation. But, I think it's probably just so ingrained these days (Alex—int¹).

Chapter 6: Findings—Developing Personal Paradigms and Theoretical Knowledge Use in Mental Health Practice

Megan further demonstrated the tacit nature of the use of occupation-focused models:

There have been times where I go back to that Occupational Performance Model. I don't sit down with it and look at it daily but I feel it always drives the way I think. It's easy for me to dredge up that stuff, it's easy for me to think back about what's impacting on occupational performance and what are the components of occupation performance? It's like something that's always there and never lost, but it's not something I consciously think of. I don't necessarily sit down with it and plan things based on the model (Megan—int²).

Developing Professionally Bilingual Skills

Participants used language from occupation-focused models to broaden their professional vocabulary. This language improved participants' ability to explain the complexity of the occupational intervention to other disciplines and managers. The development of professional bilingual skills was a key factor in how occupation-focused models were used in practice. They informed the participants' professional reasoning. Language and concepts from these models helped participants to articulate what underpinned their practice, to others. This was important, because participants felt the layers of complexity involved in occupational therapy practice were often lost on other disciplines. Colleagues only saw service users going on a walk or attending a BBQ, or completing a craft activity. While seeing the visible simple, or ordinary activity colleagues often did not understand the interactions and assessments that were conducted in vivo during these activities. Participants reflected on the difficulty to articulate the intrinsic goals of practice, or to locate evidence to support this occupation-based practice. Alex noted:

I think the really nice thing about the occupational therapy role is that when it's done well I think people don't get the significance of it because it looks so simple. And if you're dealing with someone around those core issues ... making sure they had food on the table, their bills were paid, had enough

Chapter 6: Findings—Developing Personal Paradigms and Theoretical Knowledge Use in Mental Health Practice

money to get their medication, and enough organisation to carry out all those sort of things, some of those things can be seen as really simple. I think the problem with that is people then see them as really trivial and not important (Alex – int²).

While they found the lexicon of occupation-focused models helpful, participants found professionally bilingual skills were needed to communicate with colleagues and clients. Sarah noted:

I think it [becoming bilingual] is something you could teach people and I just think that... I think that assists other people. If you can actually speak to them and this is really what we should be doing with our clients and the people we work with, being able to talk in their kind of language makes them easier to understand. And we keep talking our own language which I think is great when we talk amongst ourselves and it's great when you go and talk to an OT and, "I did blah, blah, blah" and people go, "Oh" and they say, "Oh yeah, I understand that" and you just feel validated. But if you want somebody else to understand and they come from a different profession, if you can explain that in their language it just makes it easier (Sarah – int²).

Throughout their careers, participants had developed these professional bilingual skills as an essential way of communicating with team members to allow them to understand the explicit and implicit goals of occupational interventions. They believed it was necessary to find a shared language to explain to those outside the profession how, and why people engage in ordinary daily activities (Hasselkus 2002) and the use of occupation as a means of treatment. Participants needed ways to interpret the importance of service-users' engagement in these ordinary activities. Thus, occupation-focused models assisted participants to explain the intrinsic goals of their use of occupation in diverse practice settings because there was no 'one size fits all program' in occupational therapy. Some continued to find it difficult to find a language to explain the complexity of practice. Eliza noted:

In this unit what we're going to be offering is rehabilitation...it's strongly occupational therapy stuff that we know adds value to treatment but it's so hard to articulate.

Chapter 6: Findings—Developing Personal Paradigms and Theoretical Knowledge Use in Mental Health Practice

And, when we have articulated it, management don't like the words that we use. They don't like 'living skills' and don't like the word 'self-care'. They want us to snazzy it up with some other terminology. Something that sounds more clinical and doesn't sound like an NGO [Non-Government Organisation] sector service could deliver it... I think there are not enough syllables or it's not 'niche' enough. So do we call living skills 'domestic engineering'? Is that snazzy enough? (Eliza – int²).

Sarah (int¹) explained how in her workplace she described her interventions in the language suited for her psychology colleagues, with living skills explained as: 'Adaptive behaviours in vivo'. This provided a 'shorthand' explanation that allowed the other person to understand occupational therapy from her perspective. Maria (int¹) described: 'We've been doing it like this for years. But it [MOHO] gives me the new language that's being used'. Moreover, participants viewed being professionally bilingual as an essential in the marketing of occupational therapy. The use of an occupation-focused model further assisted in raising the awareness of the occupational therapy role in mental health, to colleagues at ward rounds and meetings. In these events Liam found he had to:

Outline and justify why they should refer that person to me. So that's been an interesting process, not so much in the sense of a direct occupational therapy theory but I naturally use more occupational therapy language, 'Okay, this person could benefit from developing some of these skills and from having a graded approach over time'. And, just describing those sorts of things, if you can go back and draw on some of the language that you get from models, and that sort of thing, it sounds more convincing to doctors or clinical directors or people on other teams (Liam – int²).

University Curricula: Source of Occupation-Focused Knowledge and Models

Universities play an ongoing role as sources of occupation-focused knowledge and models. Participants regarded their contact with universities as a method of remaining current with occupation-focused

models of practice. These ongoing interactions with universities ranged from teaching in the program, marking assignments and acting as practice educators. Despite ongoing interactions with students who had established the need to remain current and to expand their knowledge, none of the participants had changed their choice of the occupation-focused model first learnt at university in the light of newer knowledge.

Using Psychological Frames of Reference

Seven participants used psychological frames of reference in their practice as summarised previously in Table 6.3. The different frames of reference used provided treatment approaches and therapies for direct use in treatment interventions. Hence, the contextual issues of the age group of service users and the service focus were factors driving the participants' use of these frames of reference.

The participants mentioned the use of different psychological frames of reference described by the American Psychological Association (2012) as 'theories of psychotherapy'. These included Acceptance and Commitment Therapy (ACT) (Hayes & Lillis 2012); Dialectical Behavioural Therapy (DBT) (Linehan et al. 1999); Narrative Therapy (Madigan 2010); Brief Solution-Focused Therapy (BSFT) (de Shazer 1988); Cognitive Behavioural Therapy (CBT) (Beck 1976) and Contemporary Attachment Theory (Schore & Schore 2008). While the participants' use of these frames of reference were explicit, the degree to which they drew on them varied from occasional use determined at a microlevel (Liam, Diana) through to participants whose macrolevel (Anna and Sarah) service delivery mode determined they were used as their primary resource in all interactions with service users in practice. Although Anna and Sarah's macroenvironments demanded that they primarily used psychological frames of reference, both retained their professional identities as

occupational therapists and viewed service-users' issues through an occupational lens.

Adding Psychological Frames of Reference to a 'Professional Toolbox'

In mental health practice, therapies were usually derived from psychological frames of reference. They were seen as being effective in reducing a service-user's barriers to their chosen occupations and valued additions to clinical skills repertoire. Bronwyn, Liam and others referred to this repertoire as a professional toolbox. Liam noted:

If I see this client could benefit from Acceptance and Commitment Therapy techniques, I'll learn about that, or goal setting, or structure from life coaching techniques. It's often about making sure I've got a range of different skills so I can respond appropriately. I'm more flexible in responding to the needs of my clients (Liam – int²).

Bronwyn explained that this professional toolbox included the therapy techniques derived from psychological frames of reference and their underpinning theoretical assumptions. However, there were differences of opinion, Alex and Eliza considered drawing on psychological frames of reference in this way unnecessary. They felt their focus solely on occupation-based interventions could be underpinned by occupational therapy philosophy. They primarily drew on their professional knowledge domain. This was often supplemented with the use of an occupation-focused model either explicitly, or more commonly, in the tacit dimension of practice.

When these psychological therapies were used in occupational therapy interventions, participants noted the focus of treatment was on identified performance components, without adaptation through an occupational perspective (Wicks & Whiteford 2003). Participants reflected this often led to an unintended change of focus away from the practitioner's occupational

Chapter 6: Findings—Developing Personal Paradigms and Theoretical Knowledge Use in Mental Health Practice

issues. Thus, psychological frames of reference were used and valued even by those participants who clearly understood the value of an occupational perspective, and the creation of goals, which addressed service-users' occupational issues through the implementation of occupation-based practice. Even though a participant may have had an occupational perspective of the service-user's issues, they had found it was often easier or necessary to use treatment interventions focused on specific performance components derived from psychological frames of references (Young & Quinn, 1992).

In addition, the use of psychological therapies derived from psychological frames of reference, often avoided the need to be professionally bilingual. Bronwyn explained, earlier in her career she had used psychological frames of reference because of the difficulties experienced in the explanation of occupational therapy to others. Megan also noted the need for occupational therapists to avoid the gap filler role in services, identified by Fortune (2000), by remaining focused on their role. However, she expanded on this by describing how theoretical knowledge underpinned her identity:

Occupational therapy isn't as tangible as Cognitive Behavioural Therapy. It is not 'manualised'. So you might be doing an intervention, and when occupational therapists talk about it, other occupational therapists understand why. Whereas other professionals seem to be stuck with the 'why'... It's not about it needing to be something that everyone can understand. That's why you're there as an OT; to do what other professionals may not be doing, rather than using a psychological-based therapy just because everyone understands and everyone knows what you're doing. [Occupation-based intervention] is going to be different (Megan – int²).

The use of these therapies was also based on research into their clinical utility, and the belief that the integration of an evidence-based technique into occupational therapy could be used to assist service-users' engagement in occupations. While Dialectical Behavioural Therapy (DBT) was not regarded as occupational therapists' core business, Maria and Liam noted

Chapter 6: Findings—Developing Personal Paradigms and Theoretical Knowledge Use in Mental Health Practice

they applied techniques from it because its techniques were known to assist people with the crisis points in their life. Thus, they adopted the use of techniques from DBT into occupational therapy in order to teach service users the ‘distress tolerance’ techniques, which could assist them to engage in chosen occupations. Thus, DBT was seen to augment their interventions. Maria suggested:

Even though I come from an occupational therapy perspective, I’m the coordinator for the DBT program locally. So my skills in that area are there, but again I don’t feel badly about that because I think DBT, even though it was a psychologist that invented it, I think she might have been a contaminated occupational therapist. DBT is nicely packaged...it was a structure that was acceptable, manualised and so I’ve stuck with it, because of the population or the diagnostic population, not so much the therapy really. And it’s evidence-based. (Maria – int²)

Megan suggested Brief Solution-Focused Therapy (BSFT) also resonated with occupational therapists because of its clinical efficacy:

Occupational therapy is a very positive sort of approach and the Brief Solution-Focused Therapy really brings out people’s strengths. It builds on their abilities, rather than trying to address their disabilities.

Somewhere along the line I got very interested in Brief Solution Focused Therapy as a technique. Yeah, I love it; it will probably be my core system for as long as I work as an OT because it’s so nicely melded with my beliefs as an OT. I think when I started to use that framework, I improved dramatically as an OT; I felt like I was a better OT as a result of that particular framework. And I think because occupational therapists are very good at talking about principles but not necessarily great at putting them into practice and some of that stuff around being strength focused and not using problem saturated language and being really consumer driven, like wholeheartedly consumer driven. It’s not like other situations when service users can have ‘a say’ but it’s still really the therapist determining goals (Megan—int¹).

Thus, BSFT was considered highly compatible with occupational therapy as it ensured the participant adopted a ‘strengths-based approach’ to therapy.

Chapter 6: Findings—Developing Personal Paradigms and Theoretical Knowledge Use in Mental Health Practice

Rather than distracting from the occupational issues, it could bring them into more direct focus through specific goal setting and discussion about how this would be graded to be achievable within specific time frames. Megan (int²) also suggested: 'It fits well with the way we think about people as occupational therapists ... It finally gave me the tools to be the OT I wanted to be'. Liam noted, the techniques from BSFT provided him with techniques for grading goals with service users:

They are really good techniques for exploring more about what the client views as their strengths or what the client wants to do to get things better. Often the clients will say, 'I've got these few goals,' but they might be 'big picture' goals like having a job or living independently in the community. Sometimes it's about breaking the goal down or they might say, 'I want to have a girlfriend,' but they're really unsure of how to move towards those things. Then, scaling things are how you can sort of say, 'Oh well if having a girlfriend is 10 and where you are at the moment is a three, what are some steps we can take?' and that's when they want to say, 'Oh well yeah if I was actually spending more time in social situations that would actually move me up to like a five (Liam – int²).

These quotations confirmed occupational therapists felt they had to rely on sources external to the profession for specific techniques to adopt and implement in occupational therapy. Megan provided a further illustration of the use of BSFT in practice. She had worked with a young man, who had attended an Early Psychosis service for four years:

This guy was someone who came into the program, sat in the corner of a group, for at least six months, we never saw his eyes. He pulled his cap down, he had his arms crossed and he sat in the corner of the room and slowly, he became more engaged. I worked one on one with him for probably two years or more...He didn't have much of a family life, didn't have friends, wasn't doing anything in terms of productive activity and it took him six months to even give us eye contact. So he was very disabled by schizophrenia, and I started using solution-focused approaches with him. We talked about study, he'd tried study before and he'd gone and become too anxious and he quit. I said, 'What was the level of anxiety you were

Chapter 6: Findings—Developing Personal Paradigms and Theoretical Knowledge Use in Mental Health Practice

experiencing?’ He indicated it was very severe and I said, ‘How long did you go to TAFE?’ ‘Oh, 8 weeks, I managed to go 8 weeks’. I was like, ‘Wow, you were that anxious and you managed to go for 8 weeks in a row? You must be really proud of yourself’. And he looked at me and he said, ‘I never thought of it like that before, I always thought of it as a failure’ and it was a really powerful moment to me because something he’d seen before as a failure, he then saw as positive, he realised he’d survived for 8 weeks, despite his symptoms and his anxiety and it really flipped that whole idea around. When I continued to use the Solution Focused Therapy with him he made radical changes. He started to do things – he’d always had this desire to design t-shirts so we talked about how we could do that. And he started doing designs, went to a printer, got quotes about getting them printed, and was going to sell them at the markets. It really changed things and he stands out as someone that BSFT worked with very well. There are other scenarios where it wasn’t quite so grand a change but for him it really helped. I think he was in a place where he’d lost hope that things were going to ever change or that he had any skills, so that was a very good framework to use with him (Megan—int¹).

The adoption of psychological frames of reference often occurred in workplaces where the participant had a joint role of case manager and occupational therapist within a community service. In this situation, the participants’ uses of psychological frames of reference were associated with case management issues, rather than discipline-based roles. In addition, Anna, Maria and Sarah worked in mental health services where the team adhered to a specific therapy approach due to its proven clinical efficacy for example, the use of Dialectical Behaviour Therapy (DBT) for people diagnosed with a personality disorder.

For other participants, the choice of therapies was determined largely by the service’s delivery mode. For example, at Anna’s workplace, which offered psychotherapy services for service users, each therapist was required to:

State an allegiance once per year to Acceptance and Commitment Therapy versus Narrative Therapy. This year DBT has been the focus, we’ve been undergoing intensive

Chapter 6: Findings—Developing Personal Paradigms and Theoretical Knowledge Use in Mental Health Practice

training. So, it is very much about, committing to that, to be adherent within that model and you're working within that model. Here I use three models with some clients, or more of an eclectic blend. I used the Conversation Model, which is another evidence-based program developed here in Australia. It's a, sort of, derivative of self-psychology by Russell Meares and it's also for working with individuals with self-harm disorder. It can be used with clients with eating disorders in a variety of issues as well. While a psychiatrist developed the Conversational Model, the people who used it are in more of a psychotherapist role but they are from all disciplines. So it's not so much a psychology held thing ... so I think it's an area that even the psychologists here really have to reset their minds to when they're working in that model. It's really looking at contingency management – behavioural principles and what for each individual is possibly a negative reinforcement so that you can work with that to really support them and make a behavioural change (Anna – int²).

Participants felt critical reflection was required when there was a choice involved in the adoption of psychological therapies derived from psychological frames of reference. Alex argued occupational therapists should discuss their implementation in practice rather than responding to trends. Sarah's comments also reflected the identified dangers in the adoption of psychological frames of reference without critique:

People get caught up in the trends. Once the trend starts clients start presenting to the service saying, 'We heard about this theory and we want to do therapy in that way', or everyone has seen the research on CBT so they want to do CBT because it's well researched, but just because it's well researched doesn't mean it works for everyone (Sarah – int²).

Liam also described, for other aspects of work in acute inpatient care, there was no need to adopt a psychological frame of reference. He found occupation-focused theoretical knowledge could direct the program and ensure groups and other activities existed, which provided service users with an:

Opportunity to be engaged in activity – a distraction or time of expression or whatever was necessary. By looking at that from

Chapter 6: Findings—Developing Personal Paradigms and Theoretical Knowledge Use in Mental Health Practice

an occupational therapy point of view, I could provide that without doing all that extra training [in psychological therapies] (Liam—int¹).

Frames of reference were thought to add to professional repertoires, as Bronwyn (int²) noted regarding her use of techniques from Cognitive Behavioural Therapy: 'It's just a tool that you're using, like goal setting or a daily activity schedule...it's just using that to guide your interventions'. Others had a more critical approach to CBT. Sarah said it was a Band-Aid approach, and Megan described how she had used CBT:

At the time it made sense and there was a lot of CBT. It was being promoted as the evidence-based practice to be used. They were talking about using CBT with psychosis and a lot of what we did do was based in the CBT type of a framework. At the time it made a lot of sense and it was fine but once I discovered the Brief Solution Focused stuff I was very much a convert to that way of thinking. The manual ... was appealing when you're young and new to have that real formula to use (Megan—int¹).

Megan compared her use of BSFT to CBT:

It [BSFT] puts you in a place of not being the expert, which is what appealed to me, but you need to sit with that discomfort of not necessarily knowing what you're going to say and there is no formula about it so it takes a lot more confidence to follow through with it, than a CBT type of way of doing things (Megan—int¹).

Thus, the use and adoption of psychological frames of reference was connected to the participants' professional identity and resilience. These factors underpinned professional confidence and their ability to live with the discomfort of providing creative interventions and not having a structured, or manualised, approach to follow. The participants who drew on frames of reference from psychology chose these over occupational therapy techniques because there was often more evidence-based research to support their efficacy in practice.

Losing the Balance: Adapting Psychological Frames of Reference Through an Occupational Perspective— Intentions vs. Realities

Seven of the nine participants saw the adoption of psychological frames of reference and their associated techniques and therapies as legitimate in their practice. They considered the therapies linked to psychological theories were shared knowledge. Those participants who used psychological frames of reference focused on the skills they provided to professional repertoires, rather than on the underlying assumptions of the psychological theory.

Most participants did not adhere to one psychological theory and drew upon an eclectic range of theories and treatment approaches. The participants were proud they did not usually adhere to a manualised approach and adapted therapies. Sarah (int²) suggested the strength of occupational therapy was practitioners could use approaches derived from psychological theories: In vivo, in the 'real world'. She felt this was one of the more marketable aspects of occupational therapy. However, there were dangers in using these frames of reference in mental health practice.

The participants noted one important step when using psychological frames of reference was their adaptation and translation to ensure the focus remained on occupational issues, rather than the service-users' performance components. Participants reflected the use of psychological frames of reference reduced the focus on occupational issues if they were not adapted. As noted by Eliza:

You see new people come along and they suddenly think, "I have to get rid of all these OT things because what's valued here is all these psychology things," and they pretty much step away from that stuff and take over the psychology stuff or they try to. And I think it's very hard. I think it's about having a good understanding of what OT is and I think some people still

Chapter 6: Findings—Developing Personal Paradigms and Theoretical Knowledge Use in Mental Health Practice

don't have that. A good understanding of OT and how you apply that to the area that you work in and then how to integrate some of the psychology or mental health stuff into core OT practice. (Eliza—int²).

Hence, they reflected the degree to which these frames of reference were adapted for use varied, based on professional identification with occupational perspectives, and service demands.

All participants noted when transitioning into mental health practice, there was a pressure to adopt frames of reference drawn from psychological theories, to seek education in therapies derived from psychological theories, and to uncritically adopt them into their practice. The pressure to adopt frames of reference, and therapies, continued throughout their careers and was often due to the existence of the dominant discourse of psychology in different environments. This belief also came from more than one of the participants' sociocultural environments, at a mesolevel from colleagues, or managers in the workplace; and at the macrolevel from the wider expectations of other occupational therapists, employers, or policy makers. These influential factors are described more fully in Chapter 7.

The pressure to use of psychological frames of reference usually came from managers and team members. It often occurred because previous occupational therapists in teams had used a psychological therapy approach and the team expected the new person to step into the same role. This was associated with colleagues' perception that psychological therapies were more validated because they had a larger, more established evidence-base when compared to occupational therapy. Bronwyn noted that this often discouraged practitioners when seeking evidence-based occupational therapy research.

The situation worsened when the pressure to use psychological frames of reference and associated therapies came from within the occupational

Chapter 6: Findings—Developing Personal Paradigms and Theoretical Knowledge Use in Mental Health Practice

therapy profession itself. All participants had experience of supervisors who had encouraged their adoption. This sometimes resulted in a loss of professional confidence as Liam's commented:

I definitely relate to the pressure of thinking that I need to do a counselling course or CBT course or, that sort of thing. I suppose looking back, I wonder whether that pressure was external, whether it was an expectation of my managers. And the more I think about it really, it wasn't. But I think it might have been something that was part of my lack of confidence as a new graduate (Liam – int²).

Those participants who did not use psychological therapies suggested this resulted in their occupational therapy peers also considering that they were 'not expert enough' (Eliza – int¹). While Eliza had not changed her practice, comments came from occupational therapy colleagues made her feel inadequate and question her skills. Liam also commented that some within the profession felt: 'As though occupational therapy knowledge wasn't enough'. Conversely, Anna whose psychotherapy service required adherence to psychodynamic or behavioural theories, felt other occupational therapists regarded her: 'As not occupational therapy enough'. This raises the issue of a perceived spectrum of professional identity within occupational therapy mental health practice, based on an adherence to professionally paradigm-specific practice as described initially by Fortune (2000) and Molineux (2011b).

Combining Different Forms of Theoretical Knowledge in Tandem—'It's a Balance'

To work creatively, practitioners drew on all forms of knowledge; factual, theoretical, practical, personal, professional and service-user knowledge as described in the adapted version of Trevithick's (2008a) unifying professional practice typology (Figure 1.2). To understand fully the dynamic interaction between the person, their environment, and their

Chapter 6: Findings—Developing Personal Paradigms and Theoretical Knowledge Use in Mental Health Practice

occupation, participants used all these forms of knowledge. The balance of their use varied and was dependent on the service-users' issues, and the practice context, with this domain foundational in directing the practical actions of the therapist (see Figure 6.3).

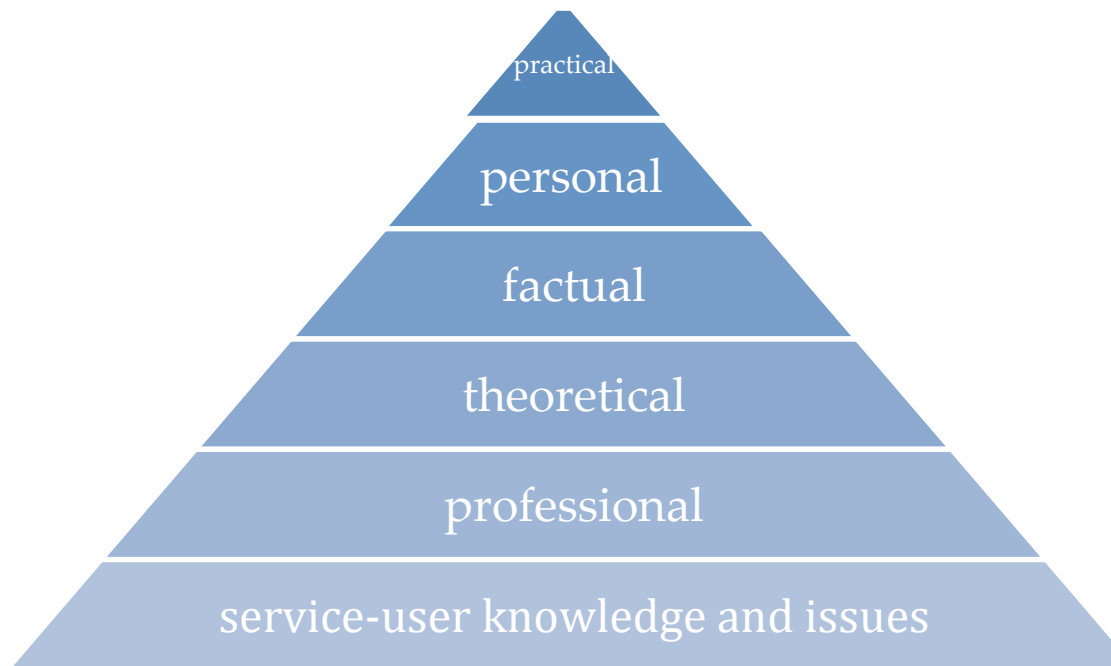


Figure 6.3: Representation of the forms of knowledge domains used in practice by the participants

Thus, the participants' references to the use of creative practice often involved a description of how they had combined a service-user's knowledge, their knowledge of service-users' occupational issues, and other knowledge domains. The aim of combining these forms of knowledge was the resolution of occupational issues. The combination of the different forms of knowledge used in encounters with service users was always contextualised. Thus, the use of occupation in treatment varied from person to person. Participants felt this was particularly true in mental health practice. They regarded this as an area of occupational therapy that allowed for varied, creative practice directed by service-users' knowledge and needs. The individual nature of practice was illustrated in a story from Liam about his experiences of working with a service user:

Chapter 6: Findings—Developing Personal Paradigms and Theoretical Knowledge Use in Mental Health Practice

A client who lives in supported accommodation has been a challenge to work with over the last period of time. She's supported by a Non-Government Organisation (NGO) that helps her with her daily living skills and prompts her to shower, groom and wear clean clothes. The agency also helps her with transport. I've taken it on myself to work, not only with this client, but also with the NGO.

Initially, this client was anxious and getting agitated and aggressive toward some of the staff. I spoke with the client and the staff. It became clear that she was very concrete in how she thought about things. For example, if I'd say something, she'd write it down. I realised that the way the NGO staffing was organised created volatility as they set up a program with her, but then changed it from day to day and week to week. She couldn't handle it. The NGO suggested her medication was reviewed, and to return to the hospital she came from because it wasn't working. I checked with the client, what was going on? We have a medication review that was useful. But, I also trained the NGO staff that because of this client's particular needs any adjustment to structure would provoke her anxiety – to avoid her agitation they needed to commit to some of these things: roster people on at certain times.

I think again about, using my [occupation-focused theoretical] knowledge to assess what was going on for the client and her needs. I looked at how the environment and the system either helped or frustrated her. I negotiated with the NGO. I talked to this client about her program and solutions – sometimes things happen where it [her behaviour] changes, and how can we manage that and try to impart some skills to the NGO about being flexible and managing her anxiety. I was working with her as an OT. The best approach is, 'this woman's not going to change how concrete she is and stuff so, the best intervention would be to address how the, how the support's being delivered to her' [adaptation of social environment] (Liam—int¹).

Combining Different Forms of Theoretical Knowledge in Tandem: Steps in Maintaining the Balance

The majority of participants felt it was necessary to use occupation-focused models in tandem with psychological frames of reference to meet service-users' occupational needs. However, in practice, both occupation-focused

Chapter 6: Findings—Developing Personal Paradigms and Theoretical Knowledge Use in Mental Health Practice

models and psychological frames of reference were valued and used in differing ways. As noted earlier, participants' use of occupation-focused models tended to be conceptual. They guided practice directions rather than instrumentally guiding practical actions in the planning and conceptualisation of assessment and interventions. Whereas, if participants used a psychological frame of reference its use was explicit. They were used instrumentally to determine practical actions and were usually combined with occupation-focused models. The ingrained, tacit use of occupation-focused models conceptually appeared to drive practice through occupation sensibilities and resulted in the instrumental use of psychological frames of reference. However, on the occasions when psychological frames of reference were used both conceptually and instrumentally to direct practice, participants reflected this limited their focus on service-users' occupational issues.

In discussing her use of psychological therapies derived from psychological theory Bronwyn presented one point of view:

These therapies, such as Cognitive Behavioural Therapy are not owned by psychology, it's a tool. Even though psychologists might have done a lot of the research, it's still a tool that we use within mental health. So I think it's more about using the framework, the OT framework, and an OT [occupation-focused] model to assess. Then having a toolkit of different things you can use that might have a psychological flavour. It might be just what you work with best in line with your personality style or just what the client works best with, rather than thinking that, occupational therapists then have a set of principles or a set of strategies that you use that's going to be applicable to everyone and anyone (Bronwyn – int²).

This belief determined how Bronwyn integrated psychological frames of reference into her personal paradigm for practice. However, as noted by Sarah, the danger in using an eclectic mix of adapted psychological therapies in practice was that the visible treatment intervention, and its underpinning theories, come from psychology. This can result in

Chapter 6: Findings—Developing Personal Paradigms and Theoretical Knowledge Use in Mental Health Practice

colleagues' confusion about an occupational therapist's role in a team, and diminish professional identity. When psychological frames of reference were used in tandem with occupation-focused models, the occupation-focused models provided the conceptual framework. The occupation-focused model often provided the tacit means or foundation, which underpinned conceptualisation and analysis of a service-user's occupational issues. Nevertheless, for the majority of the participants their visible, explicit interventions were often guided by psychological frames of reference. When techniques and therapies from psychological frames of reference were used explicitly, they were using shared knowledge, and this was another barrier when participants explained their occupational therapy role to others. The participants' tacit use of occupation-focused models, or philosophical assumptions was less obvious to others. This was because while the goal was occupation-based, the means of achieving it did not involve the direct use of occupation. In other cases, the use of psychological frames of reference diverted their attention away from occupational issues.

This explicit use of psychological frames of references and therapies by other occupational therapists had led Alex, as a team leader, to feel there was a need for more critical review of how these theories and therapies were adapted for use in practice. Furthermore, he believed there should be some discussion within the profession rather than placing the decision making on individual practitioners:

I think sometimes we need to not just embrace everything that comes along. I always say that to the staff, 'If you go to a course come back and let's talk about its relevance first,' as opposed to just saying, 'Well I just went and did a course and now I'm going to start doing everything on the ward based on this approach'.

I think sometimes decisions need to be made at a broader OT level otherwise in acute [in-patient units] we'll be talking about one thing in the community they'll be talking about another and we won't be actually talking the same thing. I think this will segregate us more as a profession and split us into these

Chapter 6: Findings—Developing Personal Paradigms and Theoretical Knowledge Use in Mental Health Practice

smaller and smaller units. I think as a profession we're probably small enough and we need to be consolidated (Alex – int²).

When the choice to use different forms of theoretical knowledge was placed solely on an individual practitioner, the consequences varied. In the early career stages, when participants were less experienced, they reflected on a loss of balance between the use of occupation-focused models and frames of reference. This had resulted in the justification of non-occupation-based practice, which relied heavily on psychological frames of reference with a focus on performance components rather than occupation. They justified this by arguing they were ultimately improving occupational participation. However, participants recalled episodes when they had lost sight of the occupational issues, the use of occupation-focused models had become marginalised and therapy approaches from psychological frames of reference dominated their practice.

Occupation-focused models were most vulnerable to marginalisation when participants were working in the highly medicalised environments of acute inpatient units, or community mental health teams. Within community mental health teams, losing the balance between the use of occupation-focused theories and psychological frames of reference was often a direct result of institutional policies and service delivery methods. In some settings, there was also a lack of any allocated occupational therapy room. Shared room arrangements made it difficult to engage in occupation-based practices. In these contexts, a participant's choice to use techniques drawn from psychological frames of reference was also affected by time and space limitations.

When recalling episodes of working in the community, all participants reflected on the limited time they could spend with service users. Time limits restricted their work within service-users' homes, or community environments. It was easier and quicker to offer clinic-based services which

Chapter 6: Findings—Developing Personal Paradigms and Theoretical Knowledge Use in Mental Health Practice

allowed them to meet preset institutional key performance indicators for client contact hours and allowed the management of caseloads. Clinic-based appointments often led to the adoption of psychological therapies and resulted in what Diana (int¹) referred to as: ‘more talking than doing’.

All the participants reflected upon how the adoption of frames of reference endangered professional identity and roles. As noted by Megan, a lack of balance between occupation-focused models and psychology frames of reference could result in a loss of focus on a service-user’s occupational issues. It was possible to ‘Dilute our skills because we’re actually trying to do our job and a range of other people’s jobs at the same time’ (Megan – int²).

Conclusion

The chapter began with descriptions of the occupational therapists’ career stages and the impact of these stages on the use of different forms of theoretical knowledge. The presentation of three participants’ narratives reflected the polar ends and middle of the spectrum of theoretical knowledge used by occupational therapists in mental health practice. These stories also demonstrated how social ecological factors at a macro, meso and microlevel influenced what participants considered to be valued theoretical knowledge, and influences on practice.

Section 1 offered a more in-depth description of participants’ integration of different forms of theoretical knowledge in mental health practice. This section explored how theoretical knowledge is combined with the occupational therapy professional knowledge domain in participants’ development of interventions. This section also included an analysis of how the use of occupation-focused models sustained occupation-based practice.

Chapter 6: Findings—Developing Personal Paradigms and Theoretical Knowledge Use in Mental Health Practice

In Section 2, the participants' use of frames of reference derived from psychological theories was explored and described how they formed part of the participants' professional toolboxes. This section also discussed the potential loss of occupation-based practice when these psychological frames of reference were used with no adaptation. Even when frames of reference were adapted using an occupational perspective, the intention to focus on occupational issues was often overtaken by the reality of practical actions that lacked a visible occupation focus. Thus, there was a perceived need for more critical reflection before adopting, and adapting new frames of reference in occupational therapy mental health practice.

The chapter concluded with a discussion of how practitioners creatively combine a multilayered use of the different forms of knowledge domains. This includes the use of different forms of theoretical knowledge in practice and the implications for occupational therapy interventions. The findings suggested participants used occupation-focused models and frames of reference in tandem. While occupation-focused models were used to conceptualise and drive the direction of therapy towards occupational goals, the use of psychological frames of reference was explicit, instrumental and determined practical actions.

In Chapter 7, I explore the macro, meso and microlevel socioecological factors with respect to the theoretical knowledge participants valued and its use in practice. This includes the professional socialisation, structures, and strategies used to ensure occupational issues remained the focus of practice.

CHAPTER 7: FINDINGS PART 2 — DEVELOPING PROFESSIONAL RESILIENCE AND THEORETICAL KNOWLEDGE USE

Three primary themes are presented. First, I present the participants' experience of living with dominant discourses in workplaces using a socioecological framework as summarised below in Table 7.1. Second, I describe the role professional resilience played in supporting the participants' use of occupational forms of theoretical knowledge. This includes a description of the strategies employed by the participants to maintain occupation-based practice and to support and enhance professional identity. Finally, I outline the ways in which different forms of professional socialisation shape the development of sociocultural aspects of theoretical knowledge within communities of practice. This is presented in relation to the development and maintenance of professional identity and resilience. It explores how dominant mental health discourses along with socioecological and sociocultural factors shaped participants' use of theoretical knowledge.

Table 7.1: Social ecological factors in the workplace

Level	Description
Microlevel	Relationships with colleagues, service users, family and friends.
Mesolevel	Workplace colleagues as informal support systems. Formal support-in-service meetings, supervision, and communities of practice at a local level.
Macrolevel	Organisational influences-teams and managers. Policy influence of service delivery. Professional organisations – broader communities of practice.

Dominant Discourse Dimensions in Mental Health Practice Contexts

As described in Chapter 2, the concept of discourse connects knowledge and power within the identity configurations of disciplines and professions (Foucault, 1980). The stories presented in Chapter 6 demonstrated how, along with service-user needs, the practice context had a central influence on participants' use of different forms of theoretical knowledge due to institutional policy and service delivery methods required of practitioners. As outlined in Chapter 6, the participants learnt to live with the tensions created by differing discourses in mental health workplaces in different ways, and to do so required participants to find the right balance. Not finding this balance, or failing to adapt psychological frames of reference, resulted in a diminishing of their professional occupational therapy identity and a change to a more generalised mental health worker. Resistance required a strong belief in what occupation had to offer as both a means of intervention, and as an end goal (McLaughlin Gray 1998).

It became clear from the data that two different discourse dimensions existed in mental health practices, and these discourses influenced participants' experience of workplaces and use of occupation-based practice. These dimensions are termed the 'practice knowledge dimension' and the 'dominant discourse dimension'. Thus, in this chapter, particular attention is paid to participants' stories relating to the dominant discourses

encountered in practice. As part of the member checking process, participants were asked if they agreed with the initial analysis and interpretation of all the data. The identification of the tensions created by dominant discourses in mental health practice resonated with all the participants.

These dimensions influenced all the participants at some point in their career. Within the data, the clearest experiences of dominant discourses were demonstrated by participants' descriptions of their experiences in transition from graduation into first jobs. Their transitions from entry-level programs with strong occupation orientations were often into workplaces, with a strong biomedical focus, such as acute inpatient settings. This first job experience was shared by eight of the participants who had worked in an acute inpatient unit within their first two years of practice. The impact of this setting on professional identity was long lasting because of the tensions created by the hegemony of biomedical discourses. Thus, participants' uses of metaphors of war were associated with the challenges associated with the need to negotiate with, and resist dominant discourses.

Participants often regarded jobs in this setting as a stepping-stone into other mental health contexts. The setting's service delivery methods were oriented around biomedical interventions with the focus on symptom reduction. This orientation frequently challenged their occupational perspective, and professional identity. Maria suggested that the reasons why new graduates were challenged in this environment was because as occupational therapists they were educated to:

'Think creatively, and view a person holistically...by looking at all aspects of that person's being from a psychosocial perspective, an occupational perspective, which doesn't always gel with the medical model (Maria—int²).

Even though participants disagreed with this perception it could result in reduced confidence. Additionally, they also contended with pressure from participants' managers to acquire generic mental health skills. This often

led to a barrage of suggested training courses on generic mental health skills, and the expectation of working in generic roles. Although participants appreciated the new knowledge, the pressure to learn this knowledge and use skills considered outside of the occupational therapy professional domain led to stress. The transition into practice involved a 'barrage of new knowledge' and a 'struggle' to survive when their employer or colleagues expected them to know skills outside of their professional domain. Despite feeling 'bombarded' with medical and generic mental health knowledge all recognised that the inpatient setting had allowed them to consolidate important generic skills.

The main difficulty experienced in acute inpatient units was the lack of validation from colleagues for occupation-based therapies. This created the constant frustration of explaining the intrinsic and extrinsic goals of treatment to others. The biomedical discourse was strongest in this setting with a focus on symptom reduction through medication. Even though the occupational therapy role was respected in this setting, all participants felt this validation was reduced when power relationships were reinforced. This was demonstrated when groups or individual sessions were interrupted, for biomedically-orientated clinical reviews, or visits from doctors. These interruptions were often described as acts of sabotage. For many when their practice was interrupted it seemed as though the power of the dominant discourses was being reinforced. This created a sense of frustration and anger because it indicated that their occupational perspective was being undermined, and disrespected by colleagues. This frequently created a sense of frustration and anger because the occupational perspective was not seen as equal in this setting. All the participants reflected that as a new graduate, it was difficult to deal assertively with these interruptions.

Practice Knowledge Dimensions

In mental health practice these dimensions include the biomedical and psychological. The findings about these dimensions are described below.

Biomedical Practice Knowledge Discourse

The tensions created by the biomedical model discourse were easier for participants to live with than tensions created by psychology, because while it informed practice, it did not shape therapy. Biomedical knowledge was seen as necessary for effective case management in the assessment of risk and symptom management. In acute settings, the main danger to occupational therapy's professional discourses was when participants enjoyed the 'importance of being central' to the management of service-users' symptoms, rather than their occupational issues. The fight to maintain their occupational perspective proved difficult when dominant discourses were also reinforced through service delivery methods. This difficulty was increased when participants were employed as generic case managers. The needs of acutely unwell community-dwelling service-users often had to be prioritized over rehabilitation oriented, community-based occupation-focused appointments with others. These tended to take longer to implement than clinic-based appointments. Occupation-based practice could become relegated behind case management issues. While some fought this and defended their time for discipline-specific practice, others enjoyed the validation and work.

Psychology Practice Knowledge Discourse

All participants felt the tension of the dominance of the psychological discourse in mental health practice. The participants considered the dominance of psychology was more of a threat to occupation-based practice than the biomedical discourse. This was because the therapies associated with psychological frames of reference offered alternative ways of solving service-users' issues. These talking therapies were regarded as

useful, but were also seen to reduce occupation-based practice. A lack of strategies to cope with this orientation could allow occupation-based practice to become displaced.

Later career experiences of working within mental health teams also required the participants to live with the tensions from the two previously mentioned discourse dimensions. However, the physical environment in this setting forced participants toward adopting the more dominant psychological theories, where clinic-based settings restricted the spaces available for group and individual occupationally focused work. They also experienced time restrictions caused by their dual roles of discipline-specific duties and case management. This created barriers to community-based in vivo activity-based therapies, and other forms of occupation-based practice.

The dominance of psychology was reflected by occupational therapy professional supervisors' suggestions participants should attend training courses, or adopt these therapies into their practice. In some ways, participants noted it was more difficult to resist adopting psychological discourses when the pressure to use them came from occupational therapy colleagues, especially those in senior positions. The pressure and encouragement from other occupational therapists to use psychological therapies resulted in some participants adopting these to direct and inform their practical actions. This was used at a conceptual level for the analysis and understanding of a service-user's issues and more concretely in consequent practical actions. Sarah noted the pressure was often greatest early in careers:

You know, how sometimes a client on a ward might want to do showering, dressing or something and a colleague says, "Can you go and do distress tolerance instead?" and you know, a new inexperienced OT is likely to say, "Yeah, yeah okay" (Sarah—int¹).

The main reason identified by participants for the dominance of psychological discourses was the success of the psychology profession in generating a broad research evidence-base perceived to be greater than that of occupational therapy. Along with the research base, the adoption of structured manualised therapies also created a more dominant and highly regarded position for psychologists. While all the participants noted that while they valued evidence-based practice, for the reasons outlined, they often indicated occupational discourses were undermined due to the relative lack of evidence for occupation-based strategies.

Dominant Discourse Dimensions: Living With The Tensions

The research interviews offered time and opportunity for participants to reflect on the reasons for remaining in workplaces. Environments became intolerable for participants when they were unable to live with the tensions created by competing discourses. They moved to mental health workplaces and stayed in jobs where they were able to employ their occupational perspective discourse, and receive validation for practice from colleagues. Often these jobs also offered more time to work with service users. While tensions were experienced in these settings due to the existence of the same triad of discourses, service delivery methods varied. For example, Diana remained in a community mental health team because she enjoyed the work and balance of the occupational discourse with biomedical and psychological discourses.

Living with the Biomedical Discourse

The biomedical discourse was strongest in acute inpatient units, and community mental health teams where medics focused on the reduction of service-users' symptoms through medication. Bronwyn suggested, it was easy for occupational therapists to 'get sucked into,' this system.

The tensions created by the dominance of the biomedical model were easier for participants to live with than those from psychological discourses. This was because participants regarded biomedical knowledge as necessary for effective case management. When it was incorporated into practice it underpinned the assessment of risk, symptom management, and treatment planning. Thus, while the biomedical knowledge informed practice, it did not shape therapy. Alex noted it was value-added knowledge for case management roles. It served as a complementary discourse for both case management and generic multidisciplinary team membership. However, in some workplaces it was dominant in the sense that the emphasis was on the biomedical aspects of service provision and could overshadow occupational perspectives. Alex said:

I think the medical model is the opposite [of occupational therapy], it reinforces that the medication is the most important thing – without that everything falls down but I've seen some really unwell people continue to live in the community, but I haven't seen well people without living skills survive very long in the community (Alex—int¹).

In settings where the biomedical discourse dominated, Diana and Maria, enjoyed the 'importance of being central' to service-users' symptom management and strongly valued case management roles. However, these roles and duties posed problems for other participants.

The generic duties of case management often resulted in the need for participants to prioritise more acutely unwell service-users' needs over those who would benefit from community-based interventions. In this situation, the participant's discipline-specific work became overwhelmed. Occupation-based practice could be easily subsumed when the needs of acutely unwell service users had to be prioritised. These genuine needs could cause the postponement of appointments with other service users who needed occupation-based interventions. Time was another factor when planning occupation-based interventions. These community-based interventions took longer to implement than clinic-based appointments.

Chapter 7: Developing Professional Resilience and Theoretical Knowledge Use

This was because occupation-based interventions usually occurred in the community, as they involved engagement and participation in vivo.

Some participants reflected they had allowed their own professional occupation-based work to be lost because they enjoyed the validation of the generic, or psychology based work they received from other team members. In contrast, other participants had fought this and defended the time to implement their discipline-specific occupation-based duties.

Diana remained in a community mental health team because she enjoyed the work and the balance of the occupational discourse with the use of biomedical and psychological discourses. Maria had shaped her employment to allow more time to work on service-users' occupational issues by negotiating for greater involvement in community work. Nevertheless, the majority of participants did not enjoy working in acute inpatient settings because these places offered little support for a professional discourse or occupation-based practice.

The need for the development of professional resilience was illustrated by participants' experiences in their first jobs. Stories about these first positions provided the clearest examples of the power of dominant discourses, and the sociocultural influences on the participants' use of the theoretical knowledge domain at a mesolevel.

The experiences of occupational therapists in acute inpatient admission units illustrated the ways in which the dominance of the biomedical model could influence professional identity and the confidence to use valued forms of theoretical knowledge and occupation-based practice initiatives. Bronwyn noted:

In the acute unit...there was lots of opportunity to use activity or use occupation and modify the environment and all those sorts of skills...but there was a very medical focus in the team overall and I felt like occupational therapy was kind of tacked on (Bronwyn— int¹).

Chapter 7: Developing Professional Resilience and Theoretical Knowledge Use

In these acute inpatient units, biomedical discourses dominated. While the occupational therapy program and a practitioner's role were appreciated, they were devalued when prioritised against medical interventions. This resulted in interruptions to occupational interventions. These interruptions were described using metaphors of battle and war – as acts of 'sabotage'. This dilemma is illustrated below.

Maria, who had spent 23 years in acute in-patient contexts, summarised the challenges of working as an occupational therapist in an acute inpatient unit:

By and large nurses work on a hierarchical basis, as do doctors to a certain extent, from their professional development. In an acute setting, that's like an army sort of level. You don't want free thinkers in the army, and nurses were the same. You did what you were told to do at this level and then someone higher made decisions. Doctors are the same – the chain of command goes down.

Whereas OTs think creatively, we look at a person holistically. Others don't. They kid themselves they look at people holistically... Occupational therapists consider all aspects of a person's being... from a psychosocial perspective, from an occupational perspective, and it doesn't always gel with the medical model. You are taught to be creative (Maria—int²).

Unlike those who had this experience as a first job episode, Maria had entered acute inpatient mental health after ten years' experience of working in a large hospital with a rehabilitation focus. While she described similar challenges which were similar to other participants she had decades of experience. Although she reported the same frustrations as the other participants, Maria relished the battle. As a more experienced practitioner she had the authority to adapt her job to include a significant amount of community work, which allowed the ongoing therapeutic and occupational engagement with service users in the community – an option not available to less experienced practitioners who were employed full-time to provide inpatient services. This adaptation to practice had allowed her to survive for 23 years in the acute environment. She remained in the midst of an

acute inpatient unit, resisting the dominant discourse and prepared: 'to do battle' every day.

Living with Recovery Approaches

All the participants mentioned the recovery approach. The introduction of this approach at macro and mesolevels, through changes in service provision, was regarded as a positive step towards a more holistic, strengths-based approach to working with service users. It was seen as a complementary discourse rather than a competing one. Liam noted, it reflected his strengths-based approach to working with service users:

I think one of the important things is amplifying the strengths that people have. You can build on someone's strengths but you can't build on their deficits I always really focus on trying to elicit from the client what they think they're doing well or what knowledge they've developed over the course of dealing with their mental illness or dealing with their mental health issues and emphasising those things as strengths and then if there are gaps or are areas where they can improve on how they're managing it that's when I can maybe offer some more information but that's my starting point is what they know themselves (Liam—int²).

However, the dominance of the biomedical model in workplaces caused dissonance when participants attempted to apply the recovery approach advocated at the macro-policy level, as Bronwyn noted:

It's really easy to fall back into that medical model and approach, because the whole service does it. And the way things are structured and even things like CHIME (electronic records system used in NSW Health) and Compulsory Treatment Orders [NSW Mental Health Act] and all those things are not recovery focused. You've got to be a bit creative in meeting those service demands but also, maintaining a recovery focus, or a client-centred focus or, all those things that we say that we do but, there's significant barriers to doing them realistically. And you've always got to be reflective in your practice; to consider it, talk about it in supervision. Sometimes the supervisor will turn around and say, 'are you listening to yourself here'? Otherwise you can feel oh God! I'm a bad OT (Bronwyn—int²).

Living with Psychology as a Dominant Discourse

The dominance of psychology in mental health practice was documented in Section 2 of Chapter 6: it was a tension perceived by all participants. They regarded the dominance of psychology as more of a threat to occupation-based practical actions because the therapies associated with it offered alternative ways of solving service-users' issues. These talking therapies were seen as useful but were also seen to take 'the doing' away from practice. A lack of strategies to cope with this incursion could result in the displacement of occupation-based practice.

Participants reflected that, with work experience, these psychological therapies required adaptation to ensure occupation-based practice. However, when they were newly qualified, they had adopted them to the detriment and neglect of occupational issues.

Other participants had experiences similar to those described in Bronwyn's story. Over time they had reflected on their own stories and realised the adoption of these psychological theories, particularly when newly qualified, had been to the detriment and neglect of occupational issues. Their adoption had resulted in more talking rather than doing. It was only the increased clinical experiences, and for some, the time to reflect during the research interviews, that allowed participants to recognise the need for psychological therapies to be adapted more judiciously to ensure they resulted in occupation-based practice.

Living with Evidence-Based Practice Discourses

All the participants noted they valued the evidence-based practice discourse. Evidence-based practice was also highly valued in participants' workplaces. Psychology was regarded as a more dominant discourse and profession within mental health practice because of its research evidence base. It was perceived as a more research orientated profession with greater numbers of publications, which supported psychological therapies. Thus,

the domination of psychology related to the success of the psychology profession in its development of a researched evidence base for practice. Participants felt it was this researched evidence base pool and then the consequent adoption of structured, manualised therapies, which created a more dominant, more highly regarded position for psychologists in mental health services. Sarah illustrated this point:

We had a major restructure a couple of years ago and one of the other clinicians, a very new member of staff, who was experienced but new here, we were talking about people were going to be spread across different services and she said, “Well, can you go to one of the other teams and we can have a psychologist because a psychologist would be more valuable than you”...I was really, obviously understandably devastated by that, because I thought to myself, “Is that what other people think? Do other people think I’m not valuable?” I mean that’s very overt, not too subtle (Sarah—int¹).

While other colleagues had supported her through this and reminded her of how valued she was in the team, Sarah remarked this comment continued to upset her.

Often participants mentioned that of the techniques they considered to be traditional, occupational therapy techniques were now embedded in psychological theories. These included the scaling techniques from BSFT, or the use of occupation to assist with mindfulness now embedded in DBT. Participants identified that a past professional flaw of occupational therapy had been the lack of documentation and research of their discipline-based skills and techniques – as noted by Maria who said: ‘We were too busy doing it to write it down’ (int²).

For the reasons outlined above, the value participants and others placed on evidence-based practice often undermined occupational discourses due to the relative lack of evidence for occupationally focused strategies in occupational therapy. This was particularly so in mental health practice. Participants felt the psychology profession was more effective in

researching and marketing than occupational therapy. Sarah, who worked in a team of psychologists, also noted:

I think occupational therapy and psychology do the opposite of each other. In psychology one person develops a program, 50 people research that project. They get 300 articles on that. That program becomes the way to go. All the other psychologists who want to treat somebody with depression pick up this tool and way of treating and just do that. Occupational therapy operates from the opposite perspective. We have 50 occupational therapists, who do 50 different things. They reinvent the wheel every time. And nobody writes any of those interventions into articles. So, another occupational therapist comes along and wants to treat, or if another 300 OTs come along and want to treat the same condition they will all develop their own program (Sarah—int¹).

Although participants described the strength of individualised occupation-based programs over psychological approaches to working with service-users, the evidence-based practice discourse dominated the choices of participants' theoretical knowledge. The dominance of psychology over occupational perspectives of health was clear. This was frequently expressed as one of the main reasons for the use of psychological frames of reference in practice. It was a key to understanding why individuals and the profession valued frames of reference from psychology over occupation-focused models.

While recognising the need to develop research supporting practice-based evidence, there was an overwhelming theme that occupational therapists were proud they did not usually adhere to a manualised approach and that they adapted therapies to create individualised programs for service-users. Sarah suggested one of the strengths of occupational therapists was the ability to use approaches derived from psychological theories *in vivo*, in the 'real world'. She felt this was one of the more marketable aspects of occupational therapy. However, Sarah saw the profession's internal use of occupational language as a barrier in the marketing of the profession, and was an advocate for the development of professionally orientated bilingual

skills. Megan (int²) noted: 'You've got to sell your goods ...it's how you word things, what you're saying, who your audience is, and pitching it at that level'. Evidence-based research provided an additional layer to add to this language.

Maintaining and Developing Professional Resilience: Strategies for Living with Tensions

As noted above, it was clear participants had developed strategies for using their valued theoretical knowledge in order to remain in the occupational therapy mental health workforce. These strategies contributed to the primary theme of professional resilience – a theme, which was common in the data from all the participants. This theme and subthemes related to it are described in Table 7.2.

Table 7.2: Themes and subthemes in the development of professional resilience

Themes – Protective factors	Sub-themes
Developing an assertive stance Developing negotiation skills	
Using occupation-focused theoretical knowledge and professional values as protective factors.	
Protecting professional identity. Knowing when it's time to leave	Leaving intolerable workplaces Fighting the fight – vanquished hero role Staying in the fight too long
Seeking support networks	Any opportunities to share a language and common belief structure and seek professional socialisation: examples included informal friendship circles (microlevel) -Supervision (microlevel) -Formal in-service monthly meetings (mesolevel)

Eliza's description of the process of developing professional resilience over time was common to all the participants:

I think you need resilience to work in mental health. I suppose you get it as you go along and it does depend on your temperament and your ability to put your hand up and say, "I need help". I was really lucky to have really good mentors and was taught to use reflective practice processes so that was helpful. But I would have handled my job quite differently now than I did then. But you do learn. And I think learn different skills from moving around a lot too.

The strategies, which assisted participants in the development of professional resilience, are discussed below (Eliza -int²).

Developing an Assertive Stance-Dealing with Competing Theoretical Discourses in Mental Health

The first step in coping with the pressures from more dominant discourses was to realise and reflect on the power relationships within teams which impacted on the use of theoretical knowledge and other aspects of practice. All the participants had experienced the repeated frustrations arising from working as a minority professional within a team. One of the greatest frustrations experienced was the need to explain to colleagues the role of an

occupational therapist, and their occupational perspectives of health. Bronwyn noted:

Hardly a week goes by when I don't have to explain that I'm an OT and qualified to work in mental health...so being there three years has barely put a dint in it [recognition of professional role] (Bronwyn—int²).

When colleagues did not understand occupational therapy interventions, participants had consciously not allowed misunderstandings to negate professional identity. Nevertheless, this had resulted in the belief that there was a lack of professional validation for occupational therapy. In many teams, Alex (int²) posited that this pressure also came for other reasons, and when colleagues asked: 'You to explain your role—it's a power thing'. His interpretation was colleagues who repeatedly asked for explanation about his occupational therapy role were: 'Saying what you do is not really relevant or important and it's so unimportant that we don't even have any awareness of what it is'. Over time Alex adopted a more assertive stance which created: 'An equal transaction' by first asking the person to explain their own role which showed: 'It's not going to be one sided'. He had shared this strategy with other practitioners. Maria noted over time she had taken on a more assertive stance:

I'm over telling everyone, they'd ask you but then not give much of themselves. So why do people assume that we know what a psychologist does, we know what a nurse does, we know what a doctor does but how come people still struggle with what an occupational therapist does? Well that's their issue not mine so I move on from that (Maria – int²).

All participants had experienced negative emotions associated with pressure from others to use psychological frames of reference rather than use their valued occupational therapy knowledge. The time they were most vulnerable to this pressure was during their transition to practice when the majority had first jobs in acute inpatient units. During the transition into new practice contexts, participants had to develop professional resilience. This was necessary to consolidate occupational therapy skills and practice

knowledge and as Eliza (int²) described: 'Learn how to be an occupational therapist'. They also had to cope with colleagues' perceptions that therapies derived from psychological theories were more valued than occupation-based skills. When occupational therapy colleagues acted as role models for new graduates used psychological frames of reference Sarah noted that:

Our core business is function. There's a whole range of OTs doing a whole range of stuff that doesn't actually necessarily focus directly on function.

With new graduates when they first start it's important to really focus on basic OT stuff and doing more OT specific interventions because I think that's the easier transferable skills. It also depends on who you get and where their focus is really. Because there's some people who...being an OT isn't their core part of who they are or what they do; it's about wanting to build skills in other areas that as OTs we don't have. So those people might have different slants (Sarah—int²).

In addition, these therapies were attractive. They provided structured, therapy skills, and techniques, which were easier to explain than occupation-based treatment techniques. The pressure to conform to these expectations was confronting because it invalidated occupational therapy knowledge learned in their professional program. Megan noted:

Other than probably the acute service that I worked in early on, every other team I've worked in has loved and valued occupational therapists. Having said that, I don't know that they really understood what OTs were about and probably, when I look back, I probably would have liked to have spent more time with people, just explaining why OTs do things. You know, why we value occupation. I don't even think other health professionals have a concept of what occupation is by our definition (Megan—int¹).

Developing Negotiation Skills

Part of developing professional resilience was learning to become more assertive and to develop negotiation skills. Although Alex, Liam, Maria and Eliza, could argue occupational therapy knowledge was enough,

others noted it was difficult to argue for, or justify occupation-based practice.

Maria reported that after over ten years in acute care settings she had more autonomy:

I've risen above the parts that I find difficult, you know the staff conflicts, or things like that, I've built a resilience – I keep reminding myself of what I'm employed for in terms of the patient. The other thing too is I've had that opportunity to flit here, flit there within this environment (Megan—int²).

This negotiation of roles was particularly difficult when practitioners stepped into jobs where a previous occupational therapist had focused on psychological theories. This led Eliza (int²) to comment on team expectations that each occupational therapist would: 'Be the same and offer the same service and to live up to expectations'.

This increased the pressure to develop negotiation skills to resist the pressure to develop practice skills based upon psychological theories. Negotiation skills impacted on participants' professional identities as they felt they had to defend the profession and their use of occupation-based practice interventions. Earlier in their professional histories, five participants reported that lack of negotiation skills resulted in their explicit use of psychological theories in practice, with occupation-focused knowledge used tacitly to interpret the service-user's occupational issues.

On reflection, Sarah felt at times, her use of psychological frames of reference had resulted in her 'losing sight' of the service-users' occupational goals and her own professional goals. Megan (int²) noted: 'We dilute our skills because we're actually trying to do our job and a range of other people's jobs at the same time'. This linked with Alex's assertion that the adoption of psychological theories by occupational therapists required more critical review by practitioners, and the broader occupational therapy profession.

Using Occupation-Focused Theoretical Knowledge and Professional Values as Protective Factors

The use of valued occupation-focused theoretical knowledge was one of the key protective factors, which sustained resilience and identity. The participants' application of occupation-focused models, and occupational therapy philosophy, to guide and conceptualise practice enabled them to retain their occupation-focus despite the challenges encountered in the workplace. Occupation-focused models allowed a conceptualisation of the means to address occupational issues. The use of the Model of Human Occupation (MOHO) (Kielhofner 2008), the Canadian Model Occupational Performance – Engagement (CMOPE) (Canadian Association of Occupational Therapists 2002; Townsend & Polatajko 2007), and Occupation Performance Model (OPM-Australia) (Chapparo & Ranka 1997), allowed participants to remain focused on occupational issues. Bronwyn described that although she used psychological frames of reference in her practice in a community service for children and adolescents:

I always see things from an occupational perspective. I focus on what am I doing that is different from what other professions can do and how can people benefit from that. In my mind, I go back to the MOHO [Model of Human Occupation]... that's the underpinning theory in my mind (Bronwyn—int²).

In addition, occupation-focused models provided a structure and occupational language to describe the complexity of occupational issues and practice to colleagues. They were used at each stage of the occupational therapy process, and often provided the means to carry out assessments. Thus, their use in guiding occupation-based interventions helped to reinforce professional identity.

Protecting Professional Identity: Knowing when it's Time to Go

Career longevity was achieved by 'knowing when it's time to go' – when to resign from a job. Megan noted the decision to leave a workplace usually occurred when the challenges experienced were thought to be insurmountable. This occurred after a prolonged period, when their efforts to change the negative features of a job had not succeeded, culminating in a sustained lack of opportunity to remain occupation-based in practice. For example, Bronwyn's experiences in private practice, which, due to the Medicare Access scheme, had left her feeling frustrated and powerless. Frequently, these challenges occurred when there was no match between a participant's professional values, and an ability to apply an occupational perspective of health in their practice. Usually, this happened in workplaces dominated by a symptom-reduction focus or the medical model of intervention. However, sometimes it was the plurality of practice, and adoption of non-occupation-based practice by other occupational therapists, which created tensions with colleagues. Colleagues' expectations of what an occupational therapist should do was coloured by previous practitioners – as Maria described:

People have a perception of what they think an OT should be doing and because you can have two OTs and they will be working quite differently, whereas you will have two nurses who won't. Psychologists don't look like they're working any differently but they might see the OTs working differently. They might see an OT as doing lots of activities and another OT that's not doing as much activities so they think, 'How come?' (Maria – int²).

Over time, the challenges of working in a job which did not match a participant's professional values offered little job satisfaction and led to his or her resignation. This strategy was a way to extend career longevity.

Seeking Support Networks: Sociocultural Dimensions and Communities of Practice

The professional socialisation available within workplaces, or in the wider occupational therapy community, anchored participants to their occupational perspective, and occupation-based practice, in the face of other dominant discourse dimensions. The opportunities to work side-by-side with other more experienced occupational therapists allowed participants to learn their strategies. If this opportunity was not available, access to formal and informal socialisation with other colleagues was also important.

The development of formal and informal professional support networks was needed to support all participants and assist them to live with tensions from the more dominant discourses. Thus, a key strategy in maintaining an occupation focus and maintaining professional resilience was the conscious engagement in professional socialisation at monthly in-service meetings, social events, or informal social networks. During their professional journeys, six participants had worked in places where they were professionally isolated, for example, as a sole occupational therapist within a team, service, or in a geographically isolated unit. All participants regarded regular professional socialisation, meeting others and sharing ideas as key factors in remaining in mental health practice when the participants experienced difficulties. Knowledge about this sense of community had attracted participants to places of work in the area. Liam explained:

I was lucky because I always had good supervision and good support around me and, not just my clinical supervisor, but also a whole network of really supportive OTs who were really strong in their identity (Liam—int¹).

Informal and formal opportunities for professional socialisation supported participants in coping with practising in difficult workplaces. Anna (int²)

noted, socialisation with other occupational therapists provided participants with opportunities to 'vent' about their lack of validation, seek problem-solving solutions, and maintain their desire to 'continue to fight' and argue for the occupational perspective. These events also showed the power of one person to act as an agent of change within their community of practice by demonstrating positively how professional resilience strategies could be used. Liam referred to the positive aspects of the existence of a professional socialisation network:

While I might not work with someone directly, I know that if I'm having a particular problem there's a person working in that area. They're really good at it, and I can give them a call. I think there's all that knowledge contained within that group. And it's really positive that it's so accessible because my preferred way of learning things is by talking to someone and asking questions (Liam—int²)

A former leader of the occupational therapists in mental health services had instigated formal monthly meetings of mental health occupational therapists. This leader had recognised the need for support from within the profession. The participants all commented on the usefulness of these monthly in-service meetings for the mental health occupational therapists. These meetings were considered integral to keeping people in the profession. Throughout their careers, attendance at these meetings allowed participants to share their ideas and simply come together with likeminded people. They provided an opportunity to discuss some of the difficulties they were facing in their team. It helped participants to know their experiences were not unique and they were not alone in their struggles and battles. This assisted in maintaining professional values – and preventing participants leaving the workplace, or the profession, when times were hard. All the participants enjoyed mental health work and did not contemplate moves to different speciality areas as an option because they reported having no affinity with non-mental health practice.

Not all meetings with other occupational therapists helped with the development of professional resilience. Much depended on the nature and content of the meeting. For example, in some meetings where discussions focused on the expert use of psychological frames of reference and therapies, therapists, who did not use these, left feeling as Eliza (int²) described: 'Bad about my OT skills'. Membership of this small community of practice reinforced dominance of these therapies within the profession and the pressures towards their inclusion. In addition, while primarily positive for socialisation, these meeting impacted on participants' feelings of professional identity or what was often referred to by participants as 'OTness'. Anna felt attending this meeting often revealed the spectrum of practice within their occupational therapy community of practice, from those who were very occupation-focused, to her own practice, which was determined by service-prescribed use of psychological frames of reference. For her, attendance sometimes had a negative impact on her self-perception of being an occupational therapist. While Anna (int²) enjoyed her work and continued to view service users through an occupational lens, she often left meetings feeling: 'Less of an OT'. The same was true for Diana who enjoyed her role as a case manager. Diana's responses about the usefulness of meetings with other occupational therapists indicated while monthly meetings were important to some, other ways of accessing socialisation may also be important. Diana admitted she had not prioritised attendance at meetings, which had left her feeling that:

The OT side of me hasn't been nurtured in recent years...I've probably done that on purpose. In the back of my mind, I think that's again due to my early ambivalence about OT, and possibly trying to distance myself from it a bit. So although I constantly put myself in that position, I am missing a lot of stuff (Diana—int²).

This ambivalence had also reduced her confidence to carry out occupation-based practice as she felt she had not had an opportunity to maintain currency. She elaborated:

I think there's fear on my side of how much I need to learn and catch up on, and again do I want to do that? I think I have to do it if I'm going to stay in the role. For my own personal benefits, and for the people that I work with, as well. But I shouldn't have to rely on having a social drink after work although it's valuable, it would be nice to be able to get that within the job as well (Diana—int²).

Professional Supervision

For all participants, supervision with an occupational therapist was considered vital in reducing the negative feeling of professional isolation. Supervision provided an opportunity to share occupational therapy ideas with someone with a shared philosophy. As noted by Liam (int²): 'good, regular, supervision with a respected occupational therapy colleague' was a key factor in maintaining professional identity and an occupational focus in practice.

Supervision provided the opportunity to discuss the challenges of working in interprofessional teams when role blurring could occur. As noted by Bronwyn, this time allowed reflection on the link between occupation-focused models and professional identity:

I'm not working in an OT role...but I'm using these [occupation-focused models] as tools. And that's what we've worked with a lot in my supervision – you're using an OT model regardless of what you do because that's how you are. That's how you develop your clinical reasoning; it is with the OT model that you spent four years learning, that you've been practising for x-amount of years now (Bronwyn—int¹).

Supervision sustained professional resilience by the sharing of experiential knowledge and adoption of shared strategies to help in the maintenance of professional identity. Time spent with supervisors could assist in developing strategies for discussing occupational therapy goals with others and give a direction for continuing education opportunities to develop clinical skills.

For supervision to be effective in supporting valued theoretical knowledge in occupation-focused models, it had to allow time for discussion of cases.

This was difficult when a participant's supervisor came from another workplace. The rationale for this removed position was for supervision sessions, which focused on broader professional issues. However, it also meant that supervisors were acting more as mentors and were often unable or unwilling to offer advice on caseloads. This style of supervision often did not provide an opportunity to discuss how a participant was using occupation with service users, or alternative strategies for occupation-based interventions, or reflection on the use of occupation-focused models.

Alex, Eliza and Sarah described their frustration that new graduates were often supervised by occupational therapists, who advocated the use of psychological frames of reference, rather than the consolidation of occupation-based practice. Eliza noted her frustration with this:

I discuss occupation-based practice with them informally then they go to supervision and come back and say, "Oh so and so told me to do narrative therapy, that's what I'm going to do (Eliza—int²).

Participants felt some supervisors' habituated behaviours and social norms were transposed on to the newly qualified therapists' thinking about what theoretical knowledge and practical actions should be in their repertoire. This kind of negative supervision experience was considered as a major force in reinforcing participants' own earlier moves into more generic, or extended, professional areas. This was especially true due to the power one of one person, where an occupational therapist, perceived as wise and powerful, advocated for moves to use DBT. Some had resisted this move, but its use by others had led to the extensive adoption of DBT within the local community of practice. As noted in Chapter 6, this was reinforced when there was a lack of critical discussion within the community of practice about the impact of the adoption of psychological frames of reference on practice.

Despite these issues, effective supervision with an occupational therapist was considered important. Effective supervision offered participants time

and space to raise uncertainties about the abstract, assumptive, conceptual nature of some occupational therapy philosophy, without feeling they were being judged. However, the supervision experience could also be negative. When they did not feel comfortable to raise doubts during supervision, it became less effective. For example, Diana found supervision stressful because she had doubts and difficulties with some of the occupational therapy philosophy from the professional knowledge domain and was more drawn towards biomedical environments where she could practice in a more generic and valued way. Then, supervision had often become a time to 'hide my true feelings' about occupation-based practice to avoid anticipated anger or disappointment from her supervisors. Diana noted fear of disappointing her supervisor reduced the opportunities to discuss how to overcome her doubts and further the implementation of occupation-based practice.

Conclusion

This chapter described the ways in which the participants experienced and developed professional resilience. It also explored the socioecological factors, which shaped what participants considered to be valued theoretical knowledge over the course of their professional journeys. It described the multiple strategies that enable the maintenance of professional resilience and professional identity. The combination of a strong professional identity, with professional resilience, enabled participants to live with the tensions created by discourses, which challenged their use of occupational perspectives. Professional socialisation within communities of practice also impacted on strengthening professional identity and resilience. In turn, the findings demonstrated professional identity was also integral in the maintenance of the participants' professional resilience. The following chapter will discuss these findings in light of the literature and theory documented in Chapters 2, 3 and 4.

CHAPTER 8: DISCUSSION

This chapter returns to this study's primary aims. It discusses the factors identified in Chapters 6 and 7, and extends the debate into what shapes practitioners' integration of different forms of theoretical knowledge into their praxis and phronesis. These findings are discussed in relation to the theories, which shed light on the factors that influenced participants' valuing and use of theoretical knowledge. For this purpose the discussion draws on Foucault's (1980) concept of dominant discourses and Habermas' (1978) categorisations of human knowledge. These theories provide the lens through which the findings of this study are reviewed with reference to power relationships and social norms.

A common thread running through the chapter is Bronfenbrenner's (1979) social ecological model. To this end an adapted version of this model is presented in Figure 8.1. The Figure is based on the findings from this study and represents the different environmental levels, which influence occupational therapists working in mental health practice.

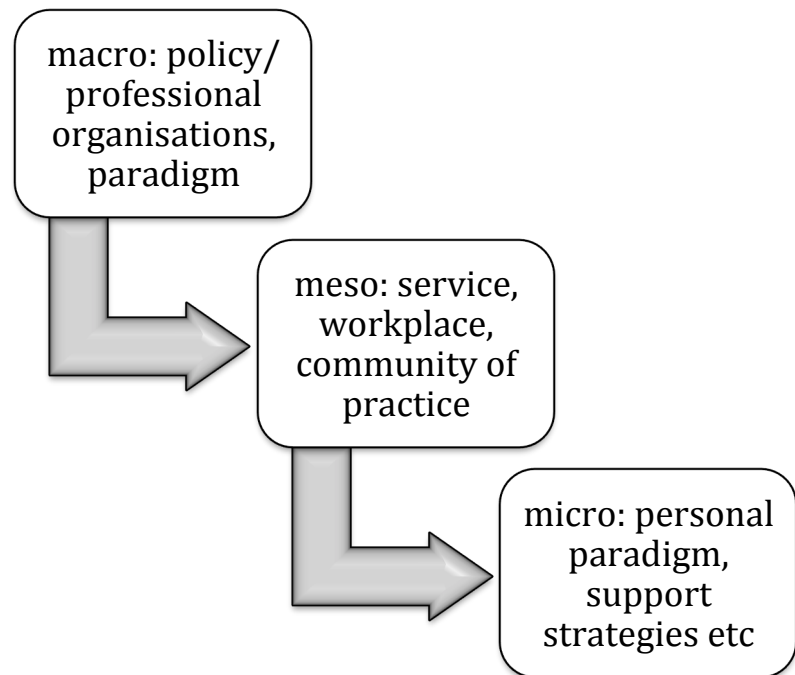


Figure 8.1: The social ecological model adapted to reflect how occupational therapists' mental health practice is influenced at different levels

These macro, meso and microlevel environmental factors are discussed within the five sections of the chapter. The first two sections focus on the two discourse dimensions in the macro, meso and microlevel environments with respect to theoretical knowledge. The other sections consider how these dimensions shape the ways in which theoretical knowledge is enacted in mental health practice.

Section 1 considers the findings that pertain to how discourse dimensions shape the ways theoretical knowledge is valued and used by practitioners. These dimensions are discussed with insights from Foucault (1980) about the ways they are manifested and experienced at macro, meso and microlevels. This is followed by a discussion of the practice knowledge dimension in the context of social norms and personal paradigm development.

Section 2 examines the strategies practitioners adopt to live with the tensions created by the two discourse dimensions identified in Section 1. This Section explores the relationship between professional resilience, professional identity, the use of valued occupation-focused models and occupation-based practice and professional knowledge domains in Australian mental health practice. It discusses the need for professional resilience, and describes strategies, which assisted participants with its maintenance and development. Professional resilience is considered in the light of professional identity spectrums and an integrated theoretical framework based on the findings presented to describe the relationship between professional identity, professional resilience and occupation-based practice.

Sections 3 and 4 explore the micro environment and the value practitioners place on different forms of theoretical knowledge and how this knowledge is embedded into, and shaped by, personal professional paradigms (Törnebohm 1991). The focus of Section 3 is on occupation-focused models with section four critically reviewing the diverse use of psychological frames of reference. Section 5 draws together the findings and an adapted typology of Trevithick's (2012) framework, which demonstrates the interactions and interplays of theoretical knowledge with other knowledge domains.

Before commencing these sections, caveats must be made. Although the professional histories of the 9 participants represent their experiences in over 50 mental health workplaces, and from 5 – 35 years of work experience, it is presumed every occupational therapist involved in practice has his or her perspective about the use of theoretical knowledge in practice and what shapes this. Nevertheless, the data analysis described in the previous chapters revealed common themes about the use and value placed on theoretical knowledge in practice by this particular group of

occupational therapists in mental health practice. These themes included how career stages shaped how theoretical knowledge was used in practice, and different multilayered socioecological factors at play in workplaces. However, there were also exceptions in participants' experiences and these are acknowledged as being important throughout the discussion.

Section 1: Dominant Discourse Dimensions and the Use and Value of Theoretical Knowledge

Section 1 utilises Foucault's concept of dominant discourses to better understand the impact of two dimensions on the use and value of theoretical knowledge. As noted in Chapter 7, I termed these the 'dominant discourse dimension', and the 'practice knowledge dimension'. These two dimensions act as the frameworks for thinking through the dynamic relationship between these aspects of practice, and how they shape the use of theoretical knowledge and professional values. The discussion places the findings in the context of contemporary discussions on paradigm-specific practice issues and the recognition of hegemonic discourses as debated by Fortune (2000), Wilding and Whiteford (2007), and Molineux (2011b).

The findings of the current study sheds light on the effects of these two dimensions on occupational therapists' practice. This illuminates some of the professional tensions experienced by occupational therapists in Australian mental health workplaces (Fortune & Fitzgerald 2009; Scanlon et al. 2010). This study found these tensions led to some participants' reduced engagement in occupation-based practice, and contributed to resignations.

Discourse Dimensions in Mental Health Practice

The findings from this study add to the debate about the ways occupation-based practice is enacted in mental health practice. They highlight the

perceived barriers to it (Lloyd, King & McKenna 2004b; Parker 2001). The use of Foucault's concept of dominant discourses to analyse the tensions, shifts the debate away from a focus on the perceived inadequacy of individual practitioners to practice with a fidelity to paradigm-dependent practice. This perspective provides new understandings of how the external pressures from hegemonic biomedical and psychological discourses can challenge professional identity because they compete, and can dominate over, occupational discourses of wellbeing.

The findings show how the reality of day-to-day practice means even practitioners with strong professional identities, who value occupationally focused theoretical knowledge, can be negatively affected by other discourses. The presence of more dominant discourses in mental health practice appears to create ongoing pressures to integrate borrowed theoretical and factual knowledge into personal paradigms. When this domination occurs, it limits the translation of the professional paradigms into practice and curtails occupation-based practice. The challenges and limitations faced by participants mirror those found in other studies of Australian and international occupational therapy mental health practice (e.g. Pettican & Bryant 2007; Scanlon et al. 2010; Wikeby, Lundgren Pierre & Archenholtz 2006).

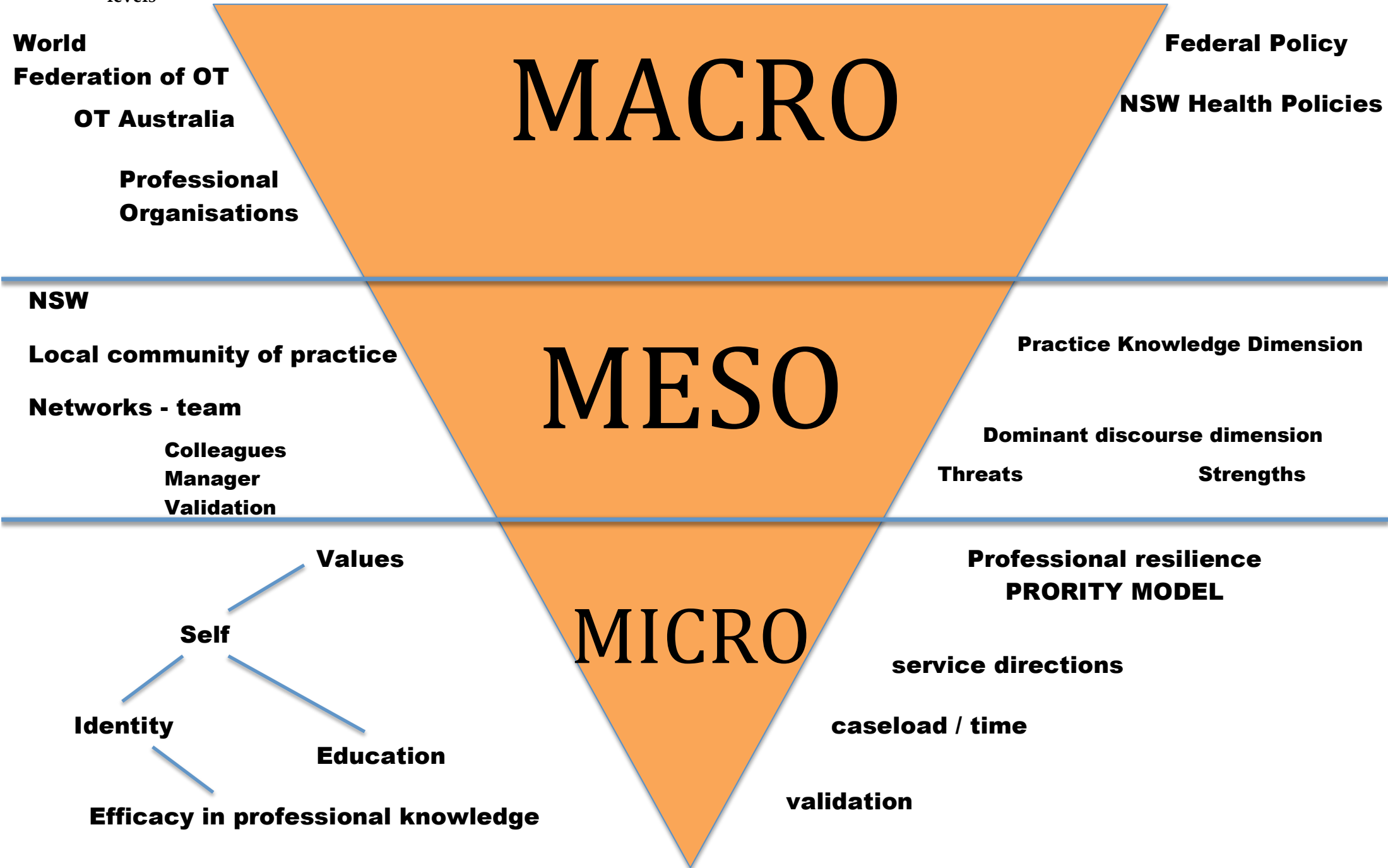
Practice Knowledge Dimension

This study found the integration of recovery approach discourses in the practice knowledge dimension was complementary with paradigm-dependent practice. This supports Reibero's (2005) view of the recovery approach positively influencing occupational therapists' practice towards occupation-based initiatives. These initiatives encourage subjective wellbeing and enable people to live with their symptoms. However, similar to, Rosen (2006b), this study found the translation of newer recovery

oriented policy (Commonwealth of Australia 2009) into practice contexts remained incomplete. This caused a dissonance between implementation at a regional public health service macrolevel, compared to the prevailing habituated biomedical, symptom management orientation at the team mesolevel. This often resulted in biomedical and psychological orientations prevailing in the discourse dimension.

In the practice knowledge dimension, participants regarded the biomedical discourse, with its focus on symptom management through pharmaceutical interventions, as supplementary and necessary to enhance their skills. This was found to be particularly true of the assessment of risk and other skills needed for case management. This corroborates with Lloyd, King and McKenna (2004b) finding that occupational therapists in mental health practice value this biomedical discourse as generic knowledge. In contrast, the participants in this study were aware that when psychological knowledge discourse was used, it impacted on all aspects of their practice, and created the most tensions within practice.

Figure 8. 2: The socioecological model adapted to reflect how occupational therapists' mental health practice is influenced at different levels



In this study, the status of the occupational therapy profession in mental health practice was often compared unfavourably with the competing psychological discourse. Returning to Foucault's (1980) concept of 'power within the professions', the psychology profession's dominance impacted on all aspects of participants' mental health practice and this shaped theoretical knowledge use. This was seen at a macrolevel when the psychological dominant discourse dimension was aligned with the biomedical discourse. This combination elevated the power of those who referred to and used the American Psychological Association DSM-IV diagnostic criteria (American Psychological Association 2000). The dominance of these discourses resulted in workplaces where the focus was on diagnosis and symptom management rather than on the occupational perspective of wellness. In private practice, conformity with the Medicare Access service scheme, described in Chapter 4, also highlighted psychological discourse dominance. In other services, this dominance resulted in an adherence to particular psychotherapies. However, even when choices were available, this dominance led some participants to use psychological frames of reference and associated psychotherapies.

In part, the attraction of the dominant psychological discourse for participants was due to its greater validation by colleagues at the mesolevel. This also reflected the broader power imbalances within interprofessional teams. This attraction extends the understanding of why role blurring and tensions affect minority professions in mental health teams (Larkin & Callaghan 2005; Nolan & Hewison 2008; Scanlon et al. 2010). In addition, the incorporation of different knowledge dimensions created the varied practices as described in the findings. This insight into the plurality of practice provides new perspectives on why some practitioners find it so difficult to explain practice and their roles to others (Fortune and Fitzgerald 2009). The following section describes how

participants within the study had dealt with the tensions created by the two discourse dimensions.

Living with the Tensions Created by Discourse

Dimensions

The study's findings illustrate the discourses faced by occupational therapists in contemporary mental health practice and the perspectives, which are dominant in the macro and mesolevel environments of health and social care. The practitioners involved in this study had all experienced the myriad ways dominant discourses operated alongside, and impacted on, using an occupational perspective. One of the contributions of this study is its unique insight into how these practitioners responded to these discourses and learned to live with the tensions operating in their professional lives. It also illustrates the impact such discourses may have on personal paradigms, praxis and phronesis at a microlevel.

The findings highlighted the ongoing nature of conflict between occupation-focused perspectives of wellness and the competing tensions created by biomedical and psychological discourses. This conflict required participants to adopt strategies to avoid the marginalization of their valued occupational perspectives and broader recovery approach discourses. These strategies were required to promote occupational discourse when the power relationships in workplaces resulted in participants constantly being subjected to other more dominant discourses. While the discourse within occupational therapy's professional literature focuses on how to preserve, or create dominance for an occupational perspective, it is important for the profession to consider how paradigm-specific occupation-based practice (Molineux 2011b) can be enacted within workplaces where there are power imbalances. The findings identified strategies that offer support for

individuals at the meso and microlevels of practice rather than apportioning blame to a practitioners' practice.

The identification of dominant discourse dimensions at the mesolevel further illustrates why minority professionals experience tensions in interprofessional teams. The findings from this study make more visible the influence of competing discourses in practice, and offer a means to analyse occupational therapists' practice behaviours. Furthermore, the study's findings illustrate how the dominant discourse and practice knowledge dimensions shape practice by influencing practitioners' use of different forms of theoretical knowledge. It also presents the strategies which participants used to negotiate living with different discourses, and to cope with the challenges which these tensions presented. Understanding these aspects of practice allows employers and managers of occupational therapists to recognise and prepare strategies to deal with these competing discourses. Strategies which make the acceptance, and greater understanding of the role of all professions, might improve the professional wellbeing of all team members through allowing each discipline to remain oriented to their professional domains, and thus reducing role blurring.

The challenges created by the two dominant dimensions identified in this study are likely to occur, in other areas of Australia, and also in the wider occupational therapy mental health community (Lloyd, King & Bassett 2002). Despite these pressures, the current study identified strategies supporting practitioners' maintenance and enactment of the occupational perspectives called for by Molineux (2011b). These strategies are discussed in the following section.

The experienced practitioners involved in this study highlighted the ways employers of occupational therapists in mental health workforce can enhance and improve recruitment and retention at the mesolevel of practice. In addition, the findings highlight the ways that the retention of

minority professions in interprofessional teams may be influenced by the two discourse dimensions present in the macro and mesolevels of mental health practice. This research showed that some practitioners who value occupation-based practice resign from workplaces that are perceived as not validating their role and practice. One strategy to combat this is the creation of workplaces where all team members know their practice is validated (Nolan & Hewison 2008; Payne 1982). The current study showed how validation could ameliorate some of the tensions caused by working in interprofessional teams where professional isolation is a known cause of occupational stress (Scanlon et al. 2010). Strong leadership at a macro and mesolevel by those who manage practitioners can promote the implementation of workplace strategies which support validation for all perspectives and which may reinforce professional resilience and identity.

Section 2: The Role of Professional Resilience in Supporting Valued Theoretical Knowledge and Occupation-Based Practice in Mental Health Workplaces

This section discusses how participants learned to live with the tensions previously discussed during their collective 129 years of work experience. The findings highlighted the importance of professional resilience in occupational therapy practice, and mirrored the earlier findings of nursing studies (Edward 2005; Hodges, Keeley & Troyan 2008). In particular, the study provides new insights and understandings of the professional self-care strategies that therapists in this study used to maintain professional resilience in mental health practice and cope with the inherent challenges of working in mental health practice.

Professional resilience in occupational therapy in this study was found to be multifaceted and associated with having a strong professional identity. It appears to be sustained when there are opportunities to use concepts and discipline-based theories to engage in occupation-based practice. However, an occupational therapist in mental health practice is likely to integrate shared workplace practice norms derived from the dominant discourse dimension previously discussed. In hostile environments, shared professional values and discipline-based theories act as emancipatory knowledge (Habermas, 1972) in the sense that they are empowering for, and ensure solidarity between, professionals within particular groups, such as occupational therapists or psychologists. However, for the most part at the mesolevel, occupational therapists' professional knowledge is shaped by the practice context, and influenced by work in multidisciplinary or interprofessional health teams.

The PRIOrity model (Ashby et al. 2013) represents the dynamic relationship found between professional resilience, professional identity and occupation-based practice at a microlevel. Figure 8.3 draws together the findings from this study and is presented as the PRIOrity model.



Figure 8.3: The PRIOrity (Professional Resilience, Identity, Occupation) model, in which occupation-based practice is supported by, and impacts on, professional resilience

The PRIOrity model indicates that while professional resilience supported occupation-based practice, this link was not automatic because it was also shaped by professional identity. In turn, a participant's professional identity is associated with the value placed on occupational perspectives of health, and the prevailing discourses and service strategies in a practitioner's workplace. The findings identified the ways in which drawing upon professional knowledge domains and occupation-focused models, and other strategies, protect professional identities (Hodges, Keeley & Grier 2005).

Similar to the professional resilience of nursing staff studied by Jackson et al. (2007), in the current study the strategies represented participants' differing stances to challenges. These stances could change over time and varied from acceptance and embracing of alternate discourses to resistance and rejection. Thus, professional resilience was found to be crucial throughout careers and was inextricably connected to professional identity

and occupation-based practice. In turn, this was underpinned by opportunities to use valued knowledge in practice.

The study found the need for professional resilience is a result of occupational therapists' minority status in many teams, along with the dominance of other discourses. These two factors increase the challenge of working in mental health practice. This is similar to those of other studies (Larkin & Callaghan 2005; Xyrichis & Lowton 2008) where health and social care professionals have expressed their role and professional knowledge was not fully appreciated by other team members. The current study emphasised the repeated incidents at the mesolevel of team members trying to disempower or question the efficacy of practitioners' occupational therapy role, or occupation-based interventions led to frustration.

As represented in the PRIOrity model, the findings indicated the participants' professional resilience was underpinned by their individual professional identity, which in turn was connected to their valuing of, and belief in, the efficacy of the role of occupational engagement in recovery from mental illness. This, along with a valuing of an occupational perspective, and confidence in the efficacy of occupation-based practice, led to this and other forms of paradigm-dependent practice being maintained. Similar to the findings of Fortune (2000) how strongly this occupational perspective was integrated into a participant's personal paradigm determined their professional identity. The findings also corroborated Törnebohm's (1991) and Björklund's (1999) argument that while the broader professional paradigm contributes to a personal paradigm, its influence is dynamic and changed by personal life experiences at the microlevel, and experiences and reactions to living with the tensions from dominant discourses, interprofessional team work, colleagues and policies, at the meso and macrolevels.

The findings reinforce the ways professional identity is interwoven with professional resilience. Both professional resilience and identity are crucial in assisting practitioners to resist the pressure to adopt, rather than adapt, psychological frames of reference and therapies. This key step of adaptation in keeping practical actions orientated to occupational issues is considered in more depth in Section 4.

The participants' experiences highlighted the role played by entry-level curricula in the development of professional identity and a belief in the efficacy of an occupational perspective of wellbeing. This finding concurred with Wood et al.'s (2000) and Whiteford and Wilcock's (2001) argument for the inclusion of occupation as a central focus of the curriculum to instigate and lay a foundation for the adoption of occupation-based practice. The current study also reinforced curricula content plays a part in a practitioner's development of an affinity with one particular occupation-focused model. These can both drive occupation-based practice and act as a protective factor in the maintenance of professional resilience (Ashby et al. 2013).

The study demonstrated when occupational therapists are employed in the broader role of case managers, or in specialist roles, service delivery models often may determine service-user needs. In these workplaces it might be inevitable occupational issues are not prioritised. In these instances, while occupational therapists have a broader duty of care to assist service users, for all participants in this study, nevertheless, the ability to work with service users in an occupationally focused manner was important as it contributed to job satisfaction. Although there were barriers to the prioritising of service-users' occupational issues and occupationally-orientated goals, the application of occupation-focused models played an essential part in ensuring these were identified.

However, while managers consider reduced retention in posts as a negative, all the participants reflected that resigning from an unsatisfying job that did not provide the opportunity to use valued theoretical knowledge, helped retention within the profession. All participants noted resignation from unsatisfying jobs was one strategy for the maintenance of professional resilience. This indicated that although employers are concerned with retention of staff in particular posts, in contrast, the individual practitioners in this study regarded the decision to leave a position as key in maintaining their longer-term retention in the profession. However, all participants saw leaving teams as a last resort. The negative experiences resulting from a lack of leadership, role blurring and lack of validation reflected the issues found in other studies (Lloyd, King & Ryan 2007; Reeves & Summerfield Mann 2004; Rosen & Callaly 2005; Stark, Stronach & Warne 2002). Over time, dealing with these issues caused diminished professional identity and was associated by participants with a loss of paradigm-dependent practice and job satisfaction. Not leaving may result in the burnout noted by Aiken et al. (2011), and Lloyd and King (2004) and subsequent lack of retention in mental health practice.

Thus, the consideration of the socioecological factors and pressures described in the participants' professional histories, provides additional insights into the difficulties with the recruitment and retention of occupational therapists in the mental health workforce (Rodger et al. 2009; Scanlon et al. 2010). The findings indicate practitioners can develop strategies to enhance professional resilience (Fink-Samnick 2009; McGee 2006). These may act as 'protective factors' when situations negate the use of paradigm-specific discipline-based knowledge and occupation-based practice and assist in the retention of occupational therapists in the workforce.

Strategies were used by participants to live with the tensions created by the competing discourse dimensions to sustain professional resilience, professional identity, and maintain occupation-based practice. This provides a greater understanding of strategies, which may support occupational therapists to live with the tensions experienced in contemporary mental health practice. An awareness and adoption of strategies at educational, managerial and practitioner levels may combat the difficulties identified by Scanlon et al. (2010) in the recruitment and retention of occupational therapists in the mental health workforce. The value and use of occupation-focused theoretical knowledge can play a role in this.

Being and Becoming Professionally Bilingual

The study shows developing a shared language to become ‘professionally bilingual’ is a key strategy in mitigating some of the difficulties of explaining the implicit and explicit ways occupation is used in practice. All professionals have unique lexicons and practitioners commonly use one in a professional context and plain English to communicate with clients. The term is used to describe the skill needed for occupational therapists to be adept at altering their disciplinary lexicon to be able to communicate with others. The vocabularies of occupation-focused models can play a role in this because they provide a useful language that assists practitioners in the explanation to others of the occupational facets of their practice. This finding was similar to Lee et al. (2012), who noted how the use of language from the MOHO could improve the professional identity of practitioners in mental health occupational therapy practice. However, while occupation-focused models can be used explicitly to describe occupation-based practice, the findings from this study indicate at times, practitioners need the ability to translate discipline-specific vocabularies, concepts, and jargon into a shared language. Thus, along with the explicit use of an occupation-

focused model's vocabulary, participants also believed it necessary to develop a translation of terms from occupation-focused models to explain how, and why occupation, and the ordinary daily activities people engage in, were used as a means of treatment (Hasselkus 2002). In this current study, the translation process was described as becoming professionally bilingual, a term which resonated with participants, and practitioners attending conference presentations of this study's findings (Ashby 2011a; Ashby, Gray & Ryan 2012).

A key step in translation with colleagues is to find the best language to explain the implicit and explicit goals of occupation-based initiatives. The development of this shared language is important to facilitate teamwork as it avoids the use of discipline-specific vocabularies, concepts, and jargon, which can act as barriers to best practice for service users (Nolan & Hewison 2008). This shared language reduced colleagues' confusion and the need for repeated explanations about the nature of occupation-based initiatives. Participants' explanations often involved the use of an occupation-focused model's vocabulary to describe the rationales underpinning different aspects of occupation-based practice, and the explicit and implicit goals of interventions to colleagues and service users (Fortune & Fitzgerald 2009). For example, the use of occupation-focused models enabled the participants to explain to others the importance of in vivo initiatives, which enabled service users to engage in ordinary, everyday activities. The use of a shared language and its translation, assisted in overcoming some of the frustrations associated with these explanations as identified in other studies (Eklund 2002; Fargion 2007; Fortune & Fitzgerald 2009; Osmond 2005; Osmond & O'Connor 2004). The difficulties in communicating occupation-based practice to others is an issue previously raised by Eklund (2000), who supported the use of occupation-focused models to be used in this manner.

The findings highlight the importance of the power relationships described by Foucault (1980) as these trigger some requests for explanations about occupation-based interventions. Nevertheless, the participants also recognised interprofessional work brought with it the need for effective communication with colleagues with differing professional philosophies, who may find it difficult to understand the occupation-paradigm and specific occupation-based practice. The study reiterated Eklund's (2002) argument that difficulties in explaining intrinsic and extrinsic goals of interventions to colleagues are intensified because practitioners design tailor made programs based on service-users' particular occupational issues. The current study highlights that the more participants used occupation-based interventions, the more frequently they were likely to be questioned. While Edwards and Dirette (2010) found autonomy and creativity helped sustain professional identity in the current study, the need to constantly explain the use of occupation in mental health practice became frustrating. Fortune and Fitzgerald (2010) also described these frustrations in mental health practice.

While becoming professionally bilingual did not overcome all the frustrations and negative feelings associated with a lack of validation for occupation-based practice, it did help sustain professional identity. This coping strategy was unconsciously, or consciously, used and involved the adoption of the language and theoretical knowledge of dominating biomedical, or psychological discourses to explain practice. This indicated that in some mental health settings it may be necessary for occupational therapists to develop and understand a shared language, because this can be used as shorthand between multidisciplinary team members. In some teams, when occupational therapists adopted this shared language, rather than detract from professional identity, it represented currency and increased professional validation from the team. More simply, becoming professionally bilingual allowed participants to be better understood by

other multidisciplinary team members. Some strategic adoption of shared language was important in the explanation of occupation-based practice to colleagues and service users. This is in contrast with Molineux's work (2011) in which the adoption of other profession's language is depicted as weakening occupational therapy's professional status. However, this study corroborates Molineux's, and Wilding and Whiteford's (2008) argument that critical reflection is needed on the extent of adoption of other professions' languages and discourses. The current study indicated the overuse of this adopted language can diminish professional identity. Thus, using shared language is a nuanced strategy which requires careful consideration.

Participants were aware that using interventions and language from psychological frames of reference initially reduced the challenges from colleagues because it avoided the need to constantly support and argue for the efficacy of occupation-based interventions. However, in some instances in the longer term, it diminished professional identity. The findings indicate that the ability to use a shared language should be considered supplementary to the key ability of explaining and articulating an occupational perspective, occupation-focused models, and occupation-based practice, to others.

Professional Socialisation

Overall, the findings of the study demonstrate the need for a nuanced approach to supporting practitioners through professional socialisation and that there is no 'one size fits all' package. Diana, who did not have a strong professional identity, illustrated the need for different approaches to meet an individual's needs. Her attitude to practice, although unique in this study, was similar to those reported in two previous studies (Lloyd, Bassett & King 2002; Lloyd & King 2004). Diana was happy to adopt case

management roles and embraced biomedical discourses. Diana's experiences and diminished professional identity may be more common in Australian mental health practice than is represented in this study.

In this study, Diana alone voiced the concerns about her lack of certainty in the assumptions inherent in the professional practice domain. Although it is intended to support practitioners, the promotion of a uniquely occupation-focused discourse by the profession can also silence the voices of practitioners who struggle with the dilemmas of trying to find an effective balance allowing them to live with ongoing, existing tensions. Hammell (2009a) and others have argued that these assumptions should be challenged and call for debate within the profession. The voicing of these concerns in entry-level education programs may encourage and assist student practitioners to become aware of debates within the profession, rather than feeling they are alone in their questioning. It may be productive for the profession to consider the creation of strategies allowing practitioners to live with a healthy tension between discourses. This alternate stance acknowledges the need to sometimes draw upon other discourses, whilst providing strategies that preserve professional identity and occupation-based practice. The participants' accounts support the work of Mackey (2007) who also found that throughout their careers, occupational therapists adopt different stances when confronted with these discourses. The current study found the adoption of more assertive stances could positively impact on the preservation of occupational perspectives in personal paradigms and consequently on occupation-based practice.

Formal and Informal Networks

The current study found opportunities for professional socialisation through formal meetings, supervision, and informal social events reinforced and developed professional identity and resilience. These networks acted as protective factors in the maintenance of professional

resilience because they created and maintained professional collegiality. These meetings kept participants socialised within the profession and reduced the negative consequences of professional isolation which was identified as a major problem by Scanlon et al. (2010).

Professional Supervision with an Occupational Therapist

To ensure occupational issues remained the focus of practice, some participants used supervision to reflect on their use of different forms of theoretical knowledge. This was one way to counter the marginalisation of occupation-based practice in mental health where the adoption of psychological therapies often contributed to role blurring and negatively impacted on professional identity. Thus, the importance of supportive, non-judgemental professional supervision by a respected occupational therapy colleague was reinforced in this study. Similar to Scanlon et al. (2010), the current study shows how supervision can support a graduate's belief in the efficacy of occupation as a therapeutic medium. It extended their findings by highlighting this strategy is of particular importance in clinical settings with a strong biomedical focus on diagnostics and symptom reduction.

In mental health practice, supervision can provide an opportunity for practitioners to reflect on how they balance the use of psychological and occupation-focused theories, and how the use of different forms of theoretical knowledge impacts on occupation-focused interventions. Supervision provides time for practitioners to reflect on the articulation of theoretical knowledge implied in their tacit understanding of their daily practice. Critical reflection allows this conceptual and tacit role to be acknowledged and brought to the surface (Eraut 1994). Maintaining a belief in the efficacy of occupation as a medium was enhanced through case-based discussions, which allowed the participants time for reflection on the role played by theoretical knowledge in their practice. But, the findings

indicated this may be dependent on participants having supervision with an occupationally-oriented supervisor. Similarly, the interview process in this research illustrated that time and specific questions are required to allow reflection on how theoretical knowledge is used in the tacit dimensions (Polyani 1966) of daily practice and how it is integrated with other knowledge domains. This process of reflecting on practice provided opportunities for the participants to consider how they balanced the use of occupation-focused models and psychological frames of reference, and how this balance impacted on occupation-based interventions.

In summary, to cope with the tensions created by dominant discourse dimensions and other challenges in the workplace, participants had used protective factors and strategies which retained them in the mental health workforce. This research adds to the understanding of the strategies supporting practitioners who may feel overwhelmed or burnt out by challenges in mental health settings (Haitham 2009; Lloyd & King 2004).

Section 3: Developing Personal Paradigms – Using Occupation-Focused Models

The following two sections consider how the study extends the empirical evidence about the contribution of theoretical knowledge to personal paradigm development at the microlevel. This section focuses on how the participants used occupation-focused models tacitly and conceptually to guide practical judgments, or phronesis, in mental health practice. It also describes their instrumental use in the definition of occupation-focused goals, and direct practical interventions.

Although Kielhofner (2009) argued that a unifying occupationally-focused paradigm exists in practice, this study shows the reality may be seen as more nuanced and pluralistic. It varies from practitioners who only drew

on occupation-focused models and the professional knowledge domain of occupational therapy, to others who had integrated psychological frames of reference into their practice. It corroborates Mosey's (1985), stance that while occupational therapy has at its core a common belief and philosophy of occupation-focused practice, the diverse settings and their influences mean its enactment is inevitably pluralistic in nature. The current study illustrates there is a broad spectrum of factors influencing how the professional paradigm is integrated into practice. The participants' use and valuing of different forms of theoretical knowledge was more akin to Mosey's pluralistic perspective, and the personal paradigms described by Törnebohm (1991) and Björklund (Björklund 1999; Björklund & Svensson 2006).

The participants' personal paradigms were shaped by their belief in the efficacy of an occupational perspective of health drawn from within occupational therapy's professional knowledge domain and paradigm. This is an important finding because it advances the knowledge of how occupational therapists develop personal paradigms. The personal paradigms of the participants reflect how socioecological environmental experiences shape the use of theoretical knowledge, professional identities, professional resilience and consequently occupation-based practice. Their descriptions of usage of theoretical knowledge also demonstrate how the pressures experienced in mental health workplaces can affect the use of theoretical knowledge, and impact on practical actions. Hence, in this study, participants' personal paradigms were shaped by the broader occupational therapy professional paradigm (Fortune 2000; Kielhofner 2009), by the dominant discourse environments, and by degrees of professional resilience. It is the interplay of the socioecological environments and sociocultural norms experienced by participants which impact on this aspect of theoretical knowledge use and personal paradigms.

Influence of University on Valuing and Using Occupation-Focused Models in Mental Health Practice

Prior to this study, little was known about how practitioners chose one occupation-focused model over another to guide practice. These findings provide a tentative explanation of why, while aspects of participants' personal paradigms were dynamic, others are stable. The participants' stories indicated personal paradigms were influenced by career stages and different workplace experiences. Nevertheless a participant's affinity and valuing of one particular occupation-focused model remained a stable component of their personal paradigms.

The study showed participants' first introduction to the socionorms and expectations of the occupational therapy profession to use occupation-focused models came from their entry-level programs. Similar to Van Deusen (1981) and Law and McColl (1989), the current study also found the entry-level curricula content on the future use of occupation-focused models was paramount. These entry-level programs remained the main source of theoretical knowledge regardless of when participants had graduated.

The entry-level education moulded and shaped the use of, and belief in, the clinical utility of occupation-focused models. This study builds on these earlier findings by explaining the familiarity and repeated application of a model was foundational in its habituated, future use throughout participants' careers. It also highlighted that this familiarity influenced why practitioners might not prioritise seeking new information about an unfamiliar occupation-focused model or update the version they had previously learnt.

These findings are similar to those of Wood et al. (2000) and Whiteford and Wilcock (2001) as they reinforce the importance university curricula

development has on professional identity formation and personal paradigms. These findings demonstrate how the explicit, or taught curriculum, in the form of case-based course content and assignments have a life long impact on occupational therapists' use of occupation-focused models. Their use is also affected by the implicit curricula through educators' opinions about the clinical utility of particular occupation-focused models.

Schell and Schell (2008) posited that an occupational therapists' personal values and beliefs could influence use of different forms of theoretical knowledge. This study indicated that when a program's curriculum included a range of occupation-focused models, a key to participants' choice of one model over another was their affinity to the concepts, frameworks, processes and language presented in the model. Another key reason for the choice of an occupation-focused model was its perceived clinical utility in working with service users in different practice contexts.

The influence of practice education off campus and on-campus curricula content, played a part in developing an affinity with mental health practice quite early in the entry-level career stage (Doherty, Stagnitti & Schoo 2009; Rodger et al. 2009). This led some participants to favour the use of MOHO (Kielhofner 2008) in case-based assignments over the Canadian Model of Occupational Performance and Engagement (CMOPE) (Townsend & Polatajko 2007) because they considered the concepts of volition and habituation allowed a greater understanding of service-users' issues in mental health practice. Those who used the MOHO felt it offered more structure, and was less abstract than other occupation-focused models. Participants relied on these perceptions because there have been no studies comparing the efficacy of the use of different occupation-focused models in practice. However, the participants noted that qualities of model use were

similar to those found by Lee et al. (2012) and they regarded MOHO as a useful model to guide mental health practice.

Transitioning into Practice: Influences on Using Occupation-Focused Models

The current study highlights the pressures faced by Australian graduates when they emerge from their entry-level programs and transition into mental health practice. These pressures come from the macro and mesolevel environments and can impact on professional identity and use of occupation-focused models in practice. While discourse dimensions shape practitioners throughout their careers, the impact was most apparent in early career stages. While the findings in this study were subject to the participants' recall of this stage in their careers, their experiences are supported by studies into new graduates' perceived preparedness for practice (e.g. Gray et al. 2012).

The current study builds upon Gray et al.s' (2012) and Hodgett et al.s' (2007) research into the transition from graduate to practice by increasing knowledge of the potential tensions occurring during this time. The transition into practice is likely to be a time when practitioners feel most vulnerable from pressure to use therapies derived from psychological frames of reference. This pressure to adopt psychological frames of reference comes at a time when they need to consolidate their valued theoretical knowledge, occupational therapy skills and occupation-based practice. The adoption of psychological frames of reference can result in a deviation away from occupation-based practice.

The transition into practice is most likely to be in acute inpatient mental health settings, which are regarded as stepping stone opportunities to consolidate graduate skills. The perception that jobs in this setting are appropriate for new graduates may be also be common in the broader

mental health workforce, as indicated by the younger aged practitioners found in a UK study by Duffy and Nolan (2005). However, the study demonstrates that while these positions are regarded as offering a foundation for future careers in some cases, the experience of dealing with an environment dominated by biomedical discourses can diminish both professional identity and confidence in occupation-based practice. This was demonstrated by the participants' stories of their early career stages in acute inpatient units. These indicated how the prioritisation of technical and process-led skills reinforced the idea these skills were more valued than the occupation-focused theoretical knowledge, which supported practical actions. If new graduates elsewhere face similar pressures, it may account for the difficulty with retention identified in other Australian and international studies (Ceramidas 2010; Duffy & Nolan 2005; Scanlon et al. 2010).

Describing the Uses of Theoretical Knowledge

While Fargion (2007) noted that many difficulties for social work practitioners in communication about their use of theoretical knowledge stemmed from the complex and often confusing language used to describe theoretical knowledge, those findings do not apply in this study. This study highlights that the participants were able to differentiate between frames of reference and occupation-focused models in discussions of theoretical knowledge. This may be because, as early as 1977, the American Association of Occupational Therapists tried to codify and consolidate different terms used to describe theoretical knowledge in entry and post-graduate level programs (Conte and Conte, 1977). The current study indicates it is practitioners' conceptual use of occupation-focused models in the tacit dimension (Polyani 1966) of practice which causes some difficulty with explanations of how they use these models in practice, rather than a problem with terminology.

This thesis builds on the profession's understanding of how occupation-focused models transition into tacit knowledge. In this study, occupation-focused models were more prone to becoming tacit than other forms of theoretical knowledge because they were habitually used conceptually in phronesis. Their use in the tacit dimension contributed to some of the difficulties and frustrations occupational therapists experience in explaining their roles and practical actions to others (Duffy & Nolan 2005; Fortune & Fitzgerald 2009). Thus, for practitioners to describe their habituated, tacit use of occupation-focused models in practice may require some degree of reflection (Schön 1983). Similar to Clandinin and Connelly's (2000) study of teachers' tacit use of theory the research interview processes provided the participants with opportunities to reflect on theoretical use in practice, and to explain how they used different occupation-focused models in practice. This deeply reflective process can identify the ways occupation-focused models are used at each stage of working with service users—in the conceptualising of occupational issues, and in the direction of practical actions. This highlights the important role reflective practice (Schön 1983) plays in allowing practitioners to find time to reflect on their use of these theories to underpin their practice, in order to make their use more explicit.

Using Occupation-Focused Models in Practice

Continuing the discussion of influences which impact on the microlevel, this study highlights the relationship between a practitioner's personal values and choice of theoretical knowledge in their professional reasoning (Schell & Schell 2008). A participant's choice to use an occupation-focused model in all aspects of phronesis was connected to personal values. Most importantly, it was connected to a belief in the efficacy of occupation both as a means and ends of working with service users (McLaughlin Gray 1998). Nevertheless, the study also demonstrates that the use of occupation-

focused models is contextualised to reflect service-users' occupational issues, within the boundaries of the practice context and the policies driving mental health service provision. This can result in practitioners in some services having limited opportunities to use the theoretical knowledge and interventions they value.

The conceptual use of occupation-focused models in the tacit dimension may highlight the reasons why previous studies (Bartlow & Hartwig 1989; Haglund et al. 2000; O'Neal, Dickerson & Holbert 2007) have reported relatively low use of occupation-focused models by practitioners. For some participants, it was only the research interview process and reflections, which uncovered the conceptual nature of occupation-focused models in the tacit dimension of praxis and phronesis. Although O'Neal, Dickerson and Holbert's (2007) research is often cited as evidence of practitioners low valuing of theoretical knowledge, the current study did not confirm this. It found all the participants valued a range of different forms of theoretical knowledge and tacitly integrated an occupation-focused model into their mental health practice.

The study demonstrates the integration of occupation-focused models into personal paradigms complements the occupational therapy paradigm-dependent practice advocated by Fortune (2000). In practice, occupation-focused models act as conceptual frameworks for practitioners, and act instrumentally to direct interventions. The participants' conceptual use of these models mirrored the ways described by Kielhofner (2009) and Iwama and Turpin (2011): Each participant used an occupation-focused model to create a framework, which was then employed to explain the process and practice of the profession. This framework then directed actions and provided concepts for a better understanding of how the service-users' environments impacted on occupational issues. However, the study showed applications of occupation-focused models in practice extended

beyond conceptualising issues. They were used instrumentally throughout all aspects of the process of resolving occupational issues. Their use affected the directions and substance of how the practitioner worked with service users—they played an instrumental role in guiding interventions towards particular aspects of occupation requiring attention.

The practical application of occupation-focused models and their perceived clinical utility in mental health practice was key. As other authors (Hooper & Wood 2002; Kortman 1994; Krefting 1985) suggest, the pragmatic nature of many occupational therapists' work means the terms used to describe theoretical knowledge have more meaning when they relate to clinical efficacy and use in research in evidence-based practice. The ways in which occupation-focused models were used was impacted on by the individual service-user's and their family's needs and the social environments in which they live (Law et al. 1996).

The findings indicate the term 'conceptual model', which is often used to describe occupation-focused models, may not be attractive to practitioners or reflect their potential uses in structuring interventions. This finding may indicate an important shift is required in the way occupationally focused theoretical knowledge is described and used. A move towards more instrumental uses may be key to encouraging occupation-based practice. In this study, when occupation-focused models were used in tandem with psychological frames of reference, the orientation of practice was changed: Whereas occupation-focused models conceptualised and drove the direction of therapy towards occupational goals, the use of psychological frames of reference was explicit, and instrumental, and determined practical actions. This can result in the instrumental use of therapies associated with a psychological frame of reference and practical actions, or praxis, which are more visibly, and explicitly psychologically oriented.

Occupation-focused models are habituated in practice. For practitioners to use or adopt new occupation-focused models may require efforts to change the culture of organisations. Some health trusts in the UK have opted for the adoption of an occupation-focused model by all practitioners – removing the element of choice and to encourage conformity across occupational services within organisations (Boniface et al. 2008; Lee et al. 2012). However, as more recently developed models emerge, or older models are revised to increase their clinical utility in mental health practice, this may reduce opportunities for individual practitioners to explore and use these other models.

For the practitioners in this study, the freedom to choose which occupation-focused model they used, led to the use of occupation-focused models encountered during entry-level programs. It may be the assimilation of more recently developed, or newer versions of existing models may encounter the same barriers identified by those exploring the transfer of the applications of research evidence-based practice (Cornelissen, Mitton & Sheps 2011; Metzler & Metz 2010). For those promoting the use of a plurality of occupation-focused models, their assimilation may require professional organisations, or educators, to provide specific, continuing education courses to change the social norms of the profession (Habermas 1972). The study showed for practitioners wanting to extend this area of their practice, the proven efficacy and clinical utility of an occupation-focused model was an important factor.

The study showed that practitioners' motivation to invest time and money to learn more about an unfamiliar occupation-focused model is low because they are unsure of its clinical utility in their specialty. Thus, they do not prioritise learning more about the model, given the demands of practice and limited time available for Continuing Professional Development (CPD). As noted earlier, in Australia, compulsory

professional registration became mandatory for all practitioners in mid-2012. This requires practitioners to identify CPD. This extrinsic macrolevel requirement may increase practitioners' motivation to seek CPD which includes the potential benefits of using occupation-focused models more instrumentally in practice and enhance opportunities for occupation-based practice. A pragmatic focus on the practical applications of occupation-focused models at the mesolevel may increase their perceived value for practitioners. This indicates the need for continued research to provide evidence for the efficacy of occupation-focused models in a range of contexts (Lee et al. 2008).

Section 4: Applying Psychological Frames of Reference in Mental Health Practice

This section begins with a further discussion of the microlevel of practice and presents the reasons participants valued and used psychological frames of reference. It then discusses how the findings illustrated the ways in which participants drew upon, and integrated psychological frames of reference into their phronesis (Kinsella & Whiteford 2009). The current study therefore builds on the work of Bartlow and Hartwig (1989) and Haglund et al. (2000) by shifting the focus away from the identification of frames of reference chosen, to a more in-depth consideration of their integration in practice and subsequent impact on the participants' practical actions. Furthermore, it continues the discussion of how dominant discourse dimensions influence participants' personal paradigms and decisions to favour this form of theoretical knowledge over occupation-focused theoretical knowledge. As identified by Kinsella and Whiteford (2009) and Schell and Schell (2008), these areas have not been thoroughly explored in previous research.

The study found the traditional use of psychological theories by Australian occupational therapists, identified by Bartlow and Hartwig (1989), continues. There is a socionorm within the profession which means that practitioners may be pressured to use theoretical knowledge from external sources and by occupational therapy colleagues. In the study, those who did not use a psychological frame of reference were in the minority. This is similar to Haglund et al.s' (2000) study where the majority of Swedish occupational therapists reported using psychological frames of reference in practice.

The findings indicate the need to debate how techniques from psychological frames of reference are regarded as 'authentic' or 'legitimate' tools for occupational therapists to use. While the controversy about legitimate tools in 'physical rehabilitation' has been debated within the profession (Friedland 1998; Greber 2011), little attention has been paid to this aspect of mental health practice. There has been a general acceptance of the use of psychological frames of reference in occupational therapy.

Influences on Valuing and Using Psychological Frames of Reference

While participants in this study had maintained their professional identity and intended to remain occupationally-focused, if they were employed in mental health work, or case management roles, this required them to conform to the policies and organisational demands implemented at the macro and mesolevels (Lloyd, Bassett & King 2002). Similar to other studies (Hughes 2001b; Lloyd, King & McKenna 2004b) the joint roles and dual service demands of case management and discipline-specific work created dilemmas for participants in their choice or use of theoretical knowledge. As noted earlier, the study confirms for some occupational therapists, it is the service directions at the mesolevel which direct adherence to a

particular theoretical stance. In addition to the biomedical discourse, in these environments, there are also pressures from other discourse dimensions for practitioners to adopt psychological frames of reference, and subjugate activity-based therapies for 'talking therapies'. In this study, case management roles necessitated the participants draw upon generic, or shared sources of mental health knowledge in order to practice, and the adoption of a different discourse focused on the service-users' biomedical needs.

The participants' professional histories and reflections on each of their career stages illustrated they were often drawn to psychological frames of reference for techniques and therapies when they did not have confidence in the efficacy of occupation-based practice to work with clients. This is problematic because it often results in practical actions directed at psychological issues rather than occupational issues. Consequently, the overuse of psychological frames of reference in mental health practice can obstruct equally important occupational issues, which ensure clients' personal and social adjustment. This may result in the difficulties described by Pettican and Bryant (2007) in sustaining occupation-based initiatives.

Viewing these experiences using Foucault's (1980) concepts of dominant discourses and power-relationships, the study indicates real-world situations require a nuanced approach to supporting practitioners. Those interested in the promotion of occupation-based practice may need to increase the awareness of graduates regarding the power relationships caused by the discourse environment's interplay with practice knowledge. Without this awareness, individual practitioners may feel isolated and choose to leave the profession (Scanlon et al. 2010), or cope by reducing occupation-based practice.

Another important influence on the use of psychological frames of reference was the participants' valuing of evidence-based practice. This

drew them towards using psychological frames of reference because of psychology's advanced evidence-base and the relative lack of research into the efficacy of occupation-based techniques. Paul (1996) noted that historically, there has been a relative lack of research into mental health practice. While other studies have identified similar valuing of evidence-based practice, they have also identified lack of evidence is also a barrier to its use (Bennett et al. 2003).

The perception of greater efficacy of psychological frames of references in dealing with pre-occupational issues, reinforced the dominance of the psychological practice knowledge discourse. This resulted in some practitioners being likely to use psychological frames of reference and associated therapies and techniques over occupation-based practice. However, while all the participants confirmed they valued implementing evidence-based practice, they 'cherry picked' therapies and techniques derived from psychological frames of reference to use them in ways which were different to the situations, or intended use, supported by the evidence (Sheldon 2000). Consequently, there is a need to grow the evidence-base for the efficacy of occupation as a means and an end of treatment in mental health practice (McLaughlin Gray 1998). In addition, it is increasingly important for occupational therapists and their supervisors to be aware of existing evidence on the efficacy of occupation-focused interventions (e.g Bullock & Bannigan 2011) and for occupation as a social dimension of health (Cook, Chambers & Coleman 2009; Eklund & Leufstadius 2007).

In this study, participants' transitions into practice highlighted the difficulty in contesting dominant discourses and associated pressures. This pressure is intensified when the use of psychological frames of reference is presented as a socionorm (Habermas 1979) by more experienced occupational therapy colleagues. The participants' professional histories result in a better understanding of the pressures, which can lead to

practitioners 'gap filling' (Fortune 2000) with activities which are psychologically, not occupationally, orientated.

Using Psychological Frames of Reference

While the conceptual knowledge behind occupation-focused models informed occupational therapists' thinking in mental health, psychological frames of reference offered alternate explanations about the causes and consequences of mental illness, and additional therapies, approaches, techniques, and skills needed to treat mentally ill people. Previous studies have often indicated the widespread use of psychological frames of reference (Bartlow & Hartwig 1989; Haglund et al. 2000). Yet this study found not all occupational therapists are drawn to using psychological therapies in practice. It also reveals the diversity of ways and scale of use by those participants who did use psychological frames of reference, from strict adherence to just using one or two psychotherapies, to a more sporadic use of specific techniques within an occupation-based practice intervention. Within this study, some participants did not use psychological frames of reference because they believed occupation-based initiatives could offer valuable contributions to all service users no matter how severe their symptoms. These participants practiced in the paradigm-specific manner advocated by Fortune (2000) and Molineux (2011) drawing only on the professional knowledge domain, and occupation-focused models and using occupation-based practice interventions to work with service-users.

Prioritisation of Psychological Issues

This study demonstrates while some practitioners do not use psychological frames of reference others consider they are a necessary step to resolve service-users' pre-occupational performance components (Ryan 2010)

which are thought to underpin a service-user's occupational issues. However, when participants reflected on this use they noted it often resulted in the provision of psychological interventions to address psychological components rather than the person's occupational issues and their roles and responsibilities in relation to those issues (Krefting 1985, Finlay 2004). Although the participants intended to focus on occupational issues, when psychological frames of reference were integrated into personal paradigms, the explicit, and instrumental use of associated therapies and techniques unintentionally displaced the more tacit or conceptual 'guidance' of occupation-focused models. This diminishes the opportunity for occupation-based practice and negatively impacts on professional identity. In addition, service-users' occupational issues can then be overlooked, which is of primary concern.

In addition to the prioritisation of pre-occupational issues, the study showed for other interventions, many practitioners compare different forms of theoretical knowledge, and make choices based on perceived clinical utility. Psychological frames of reference were considered to have more direct, structured interventions to draw on than occupation-focused models. This reduced their occupation-based interventions. These findings corroborated Hooper and Woods' (2002) argument that occupational therapists are pragmatic and place value on the most relevant and useful knowledge for practice. Furthermore, the study illustrates practitioners' attraction to the use of psychological frames of reference stems from their pragmatic valuing of the repertoires of techniques and psychotherapies they can add to a professional toolbox.

The pragmatic choices involved in the use of psychological frames of reference were not unexpected because, as Krefting (1991) suggested, they are designed to bridge the gap between theory and practice. Whereas to avoid a 'recipe book' or manualised approach, occupation-focused models

were designed to act as conceptual models, with applications in practice left to individual practitioners' creative approaches (Fish 1998; Higgs & Titchen 2001). This finding builds on those of Craik, Chacksfield and Richards (1989) who documented the relationship between creative practices in mental health and the frustrations and challenges experienced when it is enacted. The current study identified while practitioners value the ability to create tailor-made programs based on service-users' knowledge, at the same time they are attracted to the structured therapies and techne-rational skill-based approaches associated with psychology.

A key step in avoiding the diminished opportunities for occupation-based practice was the adaption and integration of psychologically-based therapies and techniques into occupation-based practices. Duncan (2006) refers to this step as requiring judicious use. However, participants noted this key step was often not possible because of the resultant pressures associated with high caseloads. The use of psychological frames of reference led to a tendency to adopt clinic-based therapies over a more lengthy community in vivo occupation-based practice, resulting in actions often based on talking techniques, rather than using occupation-based practice initiatives. This may explain why, at a time of renaissance of occupation, Pettican and Bryant (2007) noted an increased marginalisation of occupation-based practice in some mental health settings. These findings may explain the dissatisfaction found by Lloyd King and McKenna (2004b) when practitioners experience restrictions on their discipline-specific interventions.

The study shows if occupational therapists rely exclusively on borrowed psychological theories in mental health, their most visible practical actions are likely to appear to others to be psychologically orientated rather than being occupation-based. While the use of psychological frames of reference was often justified for working with people who lived with multifaceted

and complex issues, which impacted on their recovery, without the adaptation step the focus on occupational issues could be diminished.

An extensive usage of psychological frames of reference with little adaptation also made it more difficult for the participants to explain how 'occupation' was used to fulfill implicit and explicit goals (Eklund, 2000). In some cases this was because their use sometimes led to occupation-based practice not being used at all. The diminished professional identity and frustration experienced by participants is similar to the findings of Fitzgerald and Fortune (2009). The use of psychological frames of reference and their associated therapies makes it difficult to explain occupation-based practice and professional reasoning to those outside the profession. Similarly, difficulties in explaining occupation-based practice led to participants' use of psychological frames of reference.

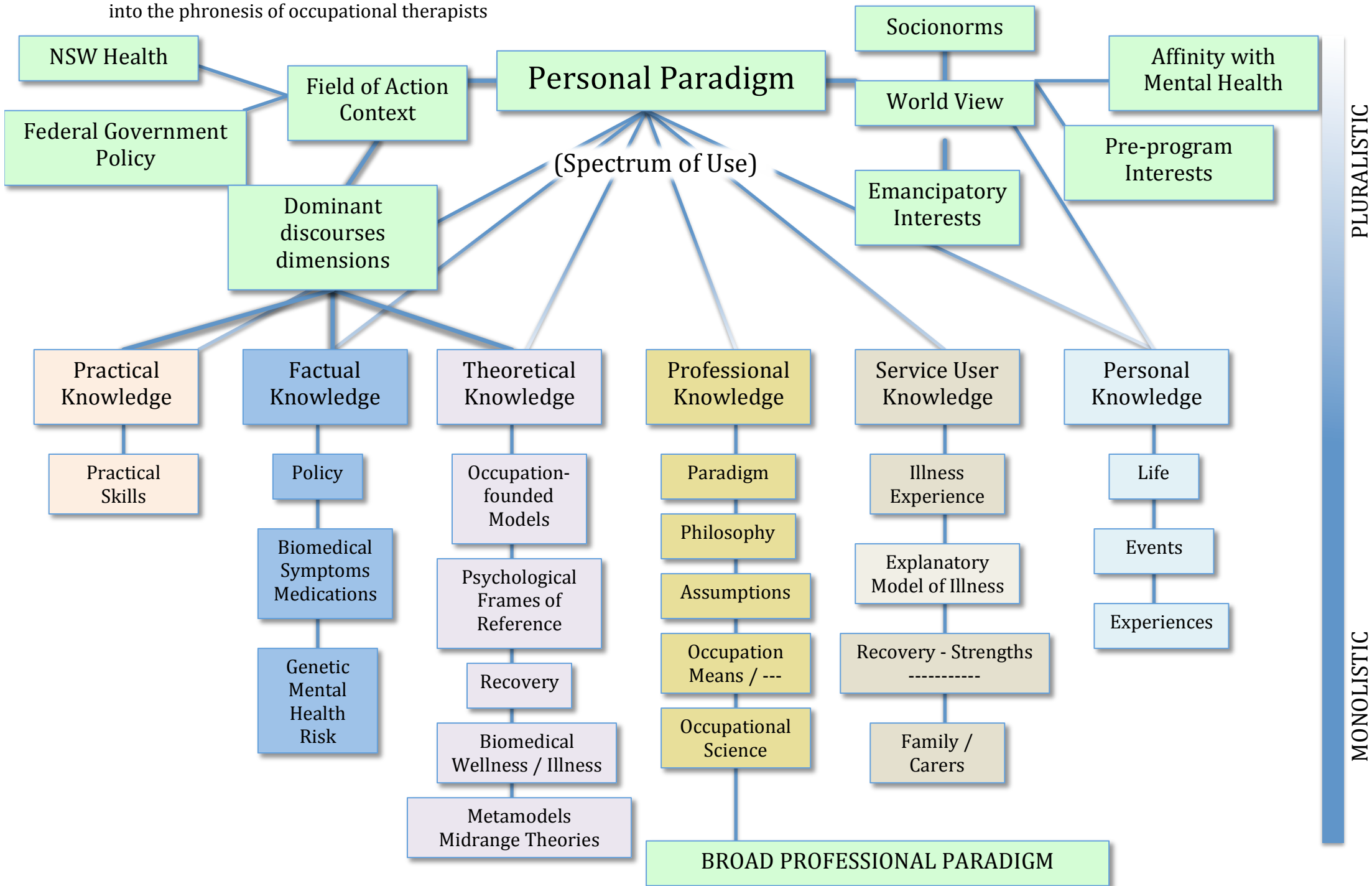
Section 5: Introducing a Unifying Professional Practice Typology for Understanding the Different Forms of Knowledge Domains Integrated into the Phronesis of Occupational Therapists

The findings highlighted the ways discipline-based theories were integrated with other domains of knowledge into their personal paradigms (Trevithick, 2012). Thus, one of the major findings of this study is a greater understanding of the ways occupational therapy practitioners integrate the theoretical knowledge domain with other forms of knowledge and the consequent influence on practical actions. Figure 8.4 presents a proposed unifying professional practice typology for understanding the different forms of knowledge domain integrated into the phronesis of occupational

therapists. It has been adapted from Trevithick's (2012) original framework to reflect the ways participants' described their occupational therapy practice.

The typology shows the varieties of interplay between the theoretical and professional practice knowledge domains. It represents how the theoretical knowledge domain is only one of the forms of knowledge drawn upon by practitioners in professional reasoning (Iwama & Turpin 2012).

Figure 8.4 Unifying professional practice typology for understanding the different forms of knowledge domains integrated into the praxis of occupational therapists



Although the focus of the study was on the use of the theoretical knowledge domain, it showed how each domain is integrated into practitioners' judgements and decision-making in professional practice by way of phronesis as illustrated in Figure 8.4. The phronesis of experienced occupational therapists integrates a range of theoretical, factual, professional, and personal knowledge domains in their practice.

The participants' case stories illustrated a service-user's expertise and their stories about their lived experience of mental illness, become part of the occupational therapy process. These stories illustrated the participants were particularly mindful of familial and social supports and how these aid service-users' adjustment following episodes of mental illness. Hence, each participant brought a broader social perspective focusing on service-users' adjustment beyond the walls of the hospital or clinic. This is why the service-users' domain is more integrated into this typology, than in the original social work model presented by Trevithick (2012), where its use is implied rather than overt. The inclusion of service-user knowledge and respect for clients about their illness experience also reflects the work of medical anthropologists, e.g., Kleinman (1988). It also acknowledges that, in a recovery-oriented contemporary mental health practice practitioners are expected to place service users at the centre of their own recovery journey (Anthony 1993; Mental Health & Drug & Alcohol Office 2006).

Consequently, the typology reflects the participants' integration of the knowledge domains was dynamic and contributed to personal paradigms (Björklund 1999). This study found in mental health practice, the presence of practice knowledge dimensions and dominant discourse dimensions at the mesolevel, can influence the use of different forms of theoretical knowledge and move personal paradigms away from the professional paradigm. To consolidate their role and professional identity in all mental health practice contexts (Lloyd, King & McKenna 2004b), occupational

therapists need to appreciate and value the professional paradigm's occupational focus. They also need to develop their professional resilience.

Conclusion

The findings from this study demonstrate the dynamic interplay between dominant discourses and practice knowledge discourses in mental health workplaces and the valuing and use of theoretical knowledge. This interplay can result in a dissonance between a practitioner's professional occupation-based paradigm and their developing personal paradigm. At the macrolevels of mental health practice, the use of theoretical knowledge is affected by organisational and government policies. At the mesolevel these demands impact on service delivery, and consequentially on occupational therapists, through local service procedures and role expectations. Thus, practitioners' use of theoretical knowledge is often adapted to demands from the practice context. It often conforms with the socionorms present in interprofessional teams which are incorporated into a practitioner's personal paradigm (Törnebohm 1991). These findings indicate future considerations and debates about occupational therapy practice knowledge must acknowledge pressures from a broader socioecological perspective rather than focusing on individuals' practice at a microlevel.

This study found that, at the microlevel, the value placed upon the use of different forms of theoretical knowledge by an occupational therapist is particular to each practitioner. This is because each practitioner's worldview is a dynamic, negotiated reality affected by his or her personal experiences and practice context (Lincoln & Guba 2003). This led to a spectrum of personal paradigms in mental health practice, which reflect practitioners' experiences of different workplaces, combined with life events and personal values. Thus, the findings highlighted the choice of

one form of theory over another is always multifactorial and context driven. The valuing of occupation-focused models and occupation-based practice was connected to the maintenance of professional resilience and professional identity at the microlevel. In turn, these are supported when a practitioner respects shared occupational therapy professional values and discipline-based theories. In the study, discipline-based theories can act as what Habermas (1972) might call emancipatory knowledge. When used they empower individuals and ensure solidarity between, occupational therapists. A valuing of occupation-focused models and the professional program began during entry-level programs. Thus, curricula content of these programs has a lasting impact on practitioners' affinity with professional domain knowledge, and subsequently on professional identity and professional resilience.

This study found new information about the nexus between occupation-focused models and practice. While participants' conceptual use of a chosen occupation-focused model remained consistent, their uses of psychological frames of reference, and other knowledge domains, were influenced by the service-user's domain and the service where they worked. This is acknowledged in the inclusion of the service-users' domain in the typology. It was the manner in which different forms of knowledge were combined, which shaped occupational therapists' practical actions towards, or away from, occupational issues. A dissonance appeared to occur between the intended focus on occupational issues and practical actions when the balance between conceptual use of occupation-focused models and psychological frames of reference errs to the use of therapies from outside the profession.

In this study, as noted earlier, the greatest pressure to use psychological frames of reference occurs during the transition into practice when they are exposed to the socionorms of the discourse dimensions of mental health

practice. In these environments, there is a tendency to use shared practice knowledge discourses derived from the more dominant discourses. This pressure is particularly strong in acute inpatient settings. Pressures to adopt psychological frames of reference pressure may also occur at the macro and mesolevels, and can come from occupational therapy colleagues.

The results of this study build on other research, which identified systemic barriers and challenges to occupation-based practice (Larkin & Callaghan 2005; Lloyd & King 2004; Molyneux 2001; Pettican & Bryant 2007). The habituated drawing on psychological frames of reference in practice can lead to the creation of socionorms within the profession, which move practice directions away from the use of occupation-focused models, and subsequently from occupation-based practice. For individual participants, arguing against existing socionorms is difficult, and hard to negotiate. This is particularly true for new graduates. Hence, to challenge these socionorms requires the development of an assertive stance to challenge occupational therapy colleagues, along with non-occupational therapy colleagues who may not understand the plurality of practice with occupational therapists drawing on differing knowledge domains. While Fortune (2000) and Molineux (2010) have argued for paradigm-dependent practice, the findings of the current study suggest a plurality of practices may be inevitable, given the range of mental health workplaces. Nevertheless, the findings indicated the importance of practitioners continuing to integrate the broader professional paradigm in practice, to ensure service-users occupational issues are addressed.

The study showed the importance for occupational therapists and their supervisors to be aware of the growing evidence on the efficacy of occupation-focused interventions, and, the importance of occupation as a social dimension of health. This is important when participants required

support for the more explicit use of occupation-focused models and occupation-based practice (Cook, Chambers & Coleman 2009; Eklund & Leufstadius 2007). In addition, the study reinforced the need to continue to develop evidence-based research to support the efficacy of occupation-focused models, and occupation-based interventions in mental health practice. This and other implications of the study and recommendations for practice are summarised in Chapter 9.

Gap Filling and Role Blurring

The consequences of practitioners' instrumental, explicit use of psychological frames of reference are practical actions, which are neither paradigm-dependent, nor occupationally oriented. The perceived need to work with service users focusing on their psychological issues can be viewed as a form of what Fortune (2000) termed 'gap filling'. In some services there is no choice, because this is determined at a mesolevel with occupational therapists expected to fulfil a range of generic and discipline-specific tasks for service users when no other professional were available. When an occupational therapist predominantly uses techniques or therapies from psychological frames of reference, rather than occupation-based techniques, they often step into a role, which could be filled by a psychologist. This role blurring can lead to tensions in teams, and colleagues' confusion, and questioning about the occupational therapy role. The potential resentments from some psychologists who consider this solely their professional knowledge domain were similar to those described by Brintell et al. (2005). This acts as a contributing factor to the tensions Nolan and Hewison (2008) identified within mental health teams.

While all participants in this study agreed occupation is a legitimate tool of occupational therapy (Wood 1996, 2011), the majority also regarded the therapies, techniques and skills drawn from psychological discourses in the

same way. As described in Chapter 6, psychological frames of reference added to their professional toolbox for use in mental health practice. The accepted and largely uncritical use of psychological frames of reference, and their associated therapies, by the majority of participants in this study, and in earlier research (Haglund et al. 2000), creates a socionorm. The findings highlight pressure from more experienced occupational therapists, who do not advocate for occupation-based practice, contributes to this socionorm.

CHAPTER 9: CONCLUSION

This chapter encapsulates the study described in this thesis by presenting the recommendations, and their implications, developed from a synthesis of the study findings. It draws on the literature, and revisits and merges the major findings from the study to discuss the importance of understanding the relationship between the valuing and use of theoretical knowledge in occupational therapy mental health. It explores the relationship between the use of occupation-focused models, professional resilience, professional identity and the use of occupation-based practice in mental health practice. It presents recommendations for practice requiring future consideration and debate at all socioenvironmental levels of the occupational therapy profession.

The recommendations relate to the original research aims. In keeping with the adaptation of Bronfenbrenner's socioecological model presented in Chapter 8 these recommendations are described in relation to: i) the broader macrolevel implications of the findings for those involved in the education of occupational therapists, ii) the implications for those involved in the employment and management of occupational therapists in the mental health workforce and iii) the implications for occupational therapists in mental health practice. Hence, Chapter 9 begins with the structural changes, which can be made at macro and mesolevels by managers and educators. This initial focus makes explicit the argument presented in Chapter 8 for the need to consider how structural reform can impact on practitioners' fidelity to more professionally paradigm-dependent practices in mental health settings. The intention of this is to shift blame away from individual practitioners. Despite this focus, the

study indicated recommendations for practitioners at the microlevel. These recommendations relate to the ways in which they can engage in strategies which maintain professional resilience through the use of occupation-focused models and occupation-based practice. Thus, the chapter summarises the ways in which recommendations for action at different environment levels can positively influence the role occupationally-focused theoretical knowledge plays in practitioners' personal paradigms and on their practical actions.

There are also recommendations for extending research into the myriad of factors, which influence the nexus between theory and practice. These recommendations reflect the importance of the relationship depicted in the PRIOrity model (Figure 8.3) between the maintenance of professional identity and the use of theoretical knowledge guiding occupation-based practice. A summary of the key findings, research recommendations, and practice implications is presented in Table 9.1.

Prior to discussion of the implications of this study on occupational therapy practice, caveats need to be made. Firstly, as a qualitative study, the findings are contextualised to one public health region of NSW, Australia, and to the nine experienced practitioners who were involved in this research. Nevertheless, the findings challenge the common discourse in occupational therapy that there is a theory—practice gap.

Chapter 9: Conclusion

Table 9.1: A summary of major findings, research implications, and practice implications

	Use of occupation-focused models	Use of psychological frames of reference	Experience of dominant discourses	Professional resilience
Major Findings	Used conceptually. Used directionally. Used instrumentally. Used tacitly. Support professional identity and in turn professional resilience.	Used directionally-instrumentally. Used explicitly – manifested in techne-rational skills and therapies. Adoption causes dissonance and issues for professional identity.	Practice knowledge domain. Dominant discourse domain.	Use of discipline-based theories to support professional resilience. Becoming professionally bilingual. Coping with the pressure to adopt psychological and other discourses. Is supported by professional socialisation and professional supervision. Knowing when it's time to go.
Practice implications	Continue with integration of occupation-focused models into curricula. Curricula for continuing professional development, needs to focus on application.	Raising awareness of how to use these psychological frames of reference. Critical reflection on their use.	Develop awareness of the power relationships present in contemporary mental health practice. Design curricula which develop assertive and negotiation strategies for occupational perspectives of health.	Develop supportive structures in practice. Develop curricula – assertive and negotiation strategies.

Table 9.1 continued

	Use of occupation-focused models	Use of psychological frames of reference	Experience of dominant discourses	Professional resilience
Research recommendations	Research the use of occupation-focused models in larger samples of occupational therapists in mental health, and within different practice contexts, and countries using mixed methods. Further research into the teaching strategies which best integrate occupation-focused models into entry-level curricula.	Research into rationales for the use of psychological frames of reference in mental health practice and their impact on occupation-based practice, and professional identity.	Research the impact of the practice knowledge dimension and dominant discourses on occupational therapy practice and occupational therapists' occupational perspective of health.	Research the professional resilience strategies of occupational therapists in mental health practice and in other practice contexts. Explore the rationale of those leaving the profession.

Implications for Educators

The findings demonstrated the ongoing nexus between the macroenvironment experienced in university entry-level programs, and the formation of personal paradigms at the microlevel. This study reinforces the role entry-level programs play in the ongoing integration of occupation-focused models in personal paradigms. The following are recommendations for those involved in the education of occupational therapists.

Curricula Design

- **It is recommended educators continue to design explicit curricula which provide students with the opportunity to become familiar with, and to critique, a range of occupation-focused models. This allows student practitioners to develop a familiarity with the model's clinical utility in case-based assessments and classroom discussions.**

The study reinforced the occupation-focused models first encountered by practitioners and applied in entry-level programs which continue to be valued and used throughout career stages. This extended the findings of the early study by Law and McColl (1989) because it identified the familiarity established with occupation-focused models in entry-level education is a key factor in this ongoing usage. This highlighted the need to mould and shape future occupational therapy curricula to include teaching strategies, which can ensure these models become embedded and habituated in practice throughout career stages.

While occupation-focused models are included in occupational therapy curricula, a study by Ashby and Chandler (2010) indicated teaching of occupation-focused models often occurs within specific courses. However, the current study highlights the importance of continuing to embed occupation-focused models throughout entry-level program curricula. The examples provided in this study indicate curriculum-based opportunities, which allow student practitioners to debate, critique and become familiar with a range of occupation-focused models, may also play a key role in these models tacit and instrumental use in practice. Assignments and activities, which require students' articulation of how occupation-focused models are used in case-based studies or program design, may improve

their ability to use language from these models to describe practice to others.

- **It is recommended educators become more consciously aware of the ways in which case-based examples about occupation-focused models form the implicit curricula, and impact on student practitioners' perceptions about the clinical efficacy of these models.**

In this study, the implicit curricula influenced participants' future use of occupation-focused models. Participants cited one of the influences for valuing and finding affinity with a particular occupation-focused model came from their educators' use of examples and support for a particular model.

The use of case-based studies and examples influenced how participants regarded a particular model's clinical utility in mental health practice. The study supports Hooper's (2006) argument for occupational therapy educators to increase their awareness about the impact of the explicit and implicit curricula. The findings highlighted the role educators can play in confirming the nexus between theoretical knowledge and occupation-based practice. The ongoing impact of entry-level programs on future use of occupation-focused models and on the efficacy of occupation-based practice corroborates Whiteford and Wilcock's (2001) call for occupation to remain central to curriculum design.

- **Educators should emphasise that competency to practice involves the more abstract, theoretical knowledge underpinnings of practice which is harder to document, praxis and phronesis, than techne-rational skills.**

In Australia, the *Australian Minimum Competency Standards for New Graduate Occupational Therapists* (OT Australia 2010) now requires entry-level programs to integrate occupation-focused models into curricula.

- **It is recommended the skills in accessing databases containing evidence for occupation-based practice continue to be included in entry-level programs and continuing professional development events (CPD). Location of this literature reinforces the existence of a growing evidence base for the efficacy of occupation-based practice in mental health.**

The study identified that evidence-based research literature influenced practitioners' choice of theoretical knowledge. While psychological theories may have a greater weight of evidence, the study indicated CPD could improve practitioners' skills in the location of evidence to support the occupation-based practice.

- **Educators should play a key role in the design of curricula, which include strategies supporting professional resilience.**

The pressures experienced by participants during their transitions into their first career stage demonstrated educators might need to play a key role in developing professional resilience strategies within curricula design. Educators can achieve this by making graduating occupational therapists aware of the professional self-care necessary for professional resilience (Ashby et al. 2013; Fink-Samnack 2009). This may be supported by inclusion of the PRIOrity model (Figure 8.3) in curricula as this emphasises the connection between professional resilience, identity and occupation-based practice.

Educators can assist in the development of entry-level curricula content, which explicitly makes graduates aware of the discourses in mental health by highlighting the potential conflicts between professional discourses in

all aspects of practice. This may allow graduates to be better prepared for the transition into practice. Increasing the awareness of these discourses is an important step in countering the potentially negative affect they can have on professional identity and choices of theoretical knowledge. The acknowledgment of their existence and increased visibility potentially counteracts a practitioner thinking that he or she is experiencing these conflicts alone. Increasing awareness of the factors that impact on professional resilience, such as the tension created by different discourses the profession's educators and managers to prepare graduates for this environment.

The study showed how participants' professional resilience was maintained by learning to be assertive. University educators could promote the development of professional identity and assertiveness abilities to support professional resilience in practice.

- **It is recommended educators play a role in instigating curricula, which encourage the development of professional bilingual skills, through debates about the use of occupation-focused language and its translation to others.**

The early development of a vocabulary to alter professional terminology, from the disciplinary lexicon of occupation-based language, so that the wider community can better understand it may improve communication. This could be achieved through interprofessional education at undergraduate and postgraduate levels (Turpin & Iwama 2011) by being built into entry-level programs through increasing interprofessional opportunities to work on case-based projects (Milburn & Colyer 2008).

The findings indicated negotiations to advocate for occupation-based perspectives in service provision could be enhanced through the ability to explain practice using a common language. This is particularly important

when colleagues may not understand the multiple ways different practitioners use occupation as a means of achieving service-users goals in practice. This is an important recommendation as the presence of dominant discourses may make it inevitable that practitioners will face these challenges in a range of mental health workplaces.

In mental health practice, the ability to communicate with multidisciplinary team members using a lexicon from the discipline of psychology, while showing its relationship to occupation-focused understandings, is essential. In these negotiations practitioners can be encouraged to use language from occupation-focused models. This is because discipline-based theories provide practitioners with alternate, explicit structures for assessment and therapy interventions, and implicit or tacit conceptual frameworks in which to consider occupational issues. They provide practitioners with additional language to describe the complexities involved in occupational therapy interventions (Eklund 2002).

Implications for Employers of Occupational Therapists in the Mental Health Workforce

The following are recommendations from the study regarding the support which employers of occupational therapists can implement to mitigate macro and mesolevel issues, which impact on how practitioners value and use theoretical knowledge. This is important in Australian contemporary mental health practice because the recruitment and retention of occupational therapy practitioners in the workforce is problematic (Scanlon et al. 2010). These recommendations may become more important as occupational therapists are increasingly employed in more generic posts or in community-based teams where they are expected to fulfill the dual role of case manager along with discipline-specific roles (Lloyd & King 2004).

Supporting Professional Resilience at Macro and Mesolevels

- **It is recommended the managers and leaders of occupational therapists in the mental health workforce ensure support strategies are in place, which can sustain occupational therapists' professional resilience. These strategies include the development of professional socialisation through the creation of formal and informal professional networking events, and attendance at CPD events which focus on discipline-specific theoretical knowledge. There is a need to ensure practitioners have effective supervision with an occupational therapist, who is occupation-based.**

The development of these strategies at a mesolevel can ameliorate some of the tensions experienced by occupational therapists, who deal with competing discourses in workplaces. These strategies can offer practitioners support and encouragement for their use of occupation-based practice. This is particularly necessary for occupational therapists in workplaces, or teams, where their occupation perspective is not validated.

From this study, it was particularly important support strategies were in place during the transition from graduation into practice. During this transition, practitioners may benefit from the role modelling and mentoring, which occurs during professional socialisation. This can be achieved through careful selection of supervisors, and support systems (Wilding, Marais-Strydom & Teo 2003). This is particularly important when first job experiences are in biomedically dominated acute inpatient units. The participants' experiences indicated if sufficient supervision and other forms of professional supervision were available for new graduates the ability to cope with these pressures was increased.

- **It is recommended occupational therapy leaders make practitioners more aware of the impact which structural power relationships have in some mental health workplaces.**

The study highlights the ways in which dominant discourses and practice knowledge dimensions impact on practitioners' choice of theoretical knowledge and subsequent occupation-based practices. Debate about these issues within the profession at the macro and mesolevels of the mental health workforce could enable occupational therapists to be better prepared for the day-to-day challenges, which often face them in practice (Scanlon et al. 2010). In mental health practice, this is particularly important when practitioners are isolated within interprofessional teams.

- **It is recommended occupational therapy leaders in mental health services assist practitioners to adopt an assertive stance and to develop negotiation skills for occupation-based practice.**

The study showed assertiveness and negotiation skills were necessary to alleviate the tensions created by the two discourse dimensions discussed in Chapter 8. The contrast between the occupational perspective and the most common practice knowledge dimensions of the biomedical, and psychological discourses, mean practitioners need to be prepared to deal with the tensions thus created. An awareness of the nature of these tensions could increase occupational therapists' preparedness to adopt an assertive stance when encountering colleagues with differing professional perspectives who question what underpins practice phronesis, or actions. The ongoing nature of the conflict between professional paradigm-dependent knowledge and more dominant discourse dimensions creates a need for occupational therapists in mental health to use these strategies throughout their careers to maintain professional resilience. The tensions in the workforce are likely to continue as the structure of contemporary

mental health services in interprofessional teams continues in community settings (Meadows, Singh & Grigg 2007).

- **It is recommended employers should provide a range of supportive strategies for practitioners in dual roles to maintain their discipline-based practice. This can include providing formal and informal feedback and validation for all team members regarding their contributions to the multidisciplinary team.**

The study identified those who manage occupational therapists should encourage practitioners to use occupation-focused models to develop more structured occupation-based interventions to ensure the focus on occupational issues is not subjugated. The encouragement by managers for practitioners to maintain their discipline-based identities and occupational orientation to practice may also reduce risk of role blurring. Xychris (2008) identified this as a major source of tension in interprofessional teams. The validation from managers and colleagues for occupation-based practice ensures a mix of perspectives is heard in these teams. This can be achieved through discussions at team level and through the setting of ground rules within teams.

- **It is recommended occupational therapy leaders should instigate structured opportunities for socialisation through the organisation of monthly in-service meetings and informal social events within services.**

The study showed the important role monthly meetings, via personal attendance or via social media, played in the reduction of participants' feelings of professional isolation. Meetings within the occupational therapy community were shown to develop strong professional networks, which created collegial support. This socialisation enhanced and maintained participants' professional resilience. An important strategy helping

practitioners deal with the negative impact of living with competing discourses in workplace, or teams, where their occupational perspective may not be validated (Nolan and Hewson, 2005). This socialisation can also occur at events organised by professional organisations and Special Interest Groups.

Socialisation with like-minded practitioners can validate the value placed on occupation-focused theoretical knowledge and support their continued use in practice. The findings showed attendance at professional and informal events plays an important role in modelling and reinforcing socionorms for occupation-based practices within a community of practice. Social media sites and services also offer alternative ways of engaging in professional socialisation and education. McGee (2006) identified all forms of professional socialisation provide collegiate support, validation and sharing of practice knowledge can nurture traits of resilience in self, students and colleagues.

For those seeking to recruit and retain occupational therapists into the mental health workforce these are important considerations. These strategies may also be used to support other minority professions in these workplaces (Lloyd & King 2004; Lloyd, King & McKenna 2004b). The availability of these strategies may be particularly important for new graduates transitioning into mental health practice. The introduction of these along with the other initiatives by managers outlined at the macro and mesolevels could extend the career longevity of the Australian occupational therapy mental health workforce (Ceramidas 2010).

Supervision

- **It is recommended employers provide occupational therapists with effective supervision to support professional resilience and the use of valued occupation-focused models.**

The findings suggested there is not enough supervision and built-in reflection across a number of domains of occupational therapy practice. The study particularly highlighted the need for practitioners to seek structured, effective, formal supervision with an experienced non-judgmental, occupationally focused occupational therapist. Attendance at supervision meetings allows opportunities for reflection on what informs their phronesis—their judgments, and praxis, and their practical actions—the nexus between theory and practice. The provision of this style of supervision may require further training for supervisors. It may also require the profession to consider introducing mandatory minimum requirements for supervision of practitioners, such as those initiated by other professions.

This study illustrated the importance of using the formal time provided in supervision to reflect on practice. It demonstrated the need for participants to overtly reflect on their practice, to identify the workings of occupation-focused models in their clinical practice. An awareness of occupation-focused models used in practice is important in ensuring practitioners are able to articulate their use. The findings also identified the importance of facilitating discussions on the use of theory in practice. These discussions could take the form of learning circles or more formalised communities of practice (Wenger, McDermott & Snyder 2002).

Supervision, along with CPD and learning circle activities may also provide opportunities to seek advice on the techniques involved in becoming professionally bilingual and acquiring the skills, which are needed to articulate the use of theoretical knowledge. Both supervision and CPD also offer avenues for critical debates on the use of different forms of theoretical knowledge and their potential effects on occupation-based practice. In addition, reflection and debate allow time for discussion of the most

effective ways to design tailor-made programs using paradigm-dependent occupation-based interventions to meet service-users' needs. This requires practitioners to consider how they draw on, and integrate diverse forms of knowledge: theoretical, factual, personal, practical, service-user knowledge (Trevithick 2008b; Trevithick 2012) and the implications for practice.

Implications for Occupational Therapy Mental Health Practitioners

The study demonstrated the multiple ways different forms of theoretical knowledge are used in mental health practice. The participants' experiences demonstrate how personal paradigms are influenced by socio environmental contexts. Their reactions to entry-level education, along with the events, which unfold as they transition through career stages contribute to and shape the use of different forms of theoretical knowledge. Consequently, each of these factors contribute to the spectrum of personal paradigms described by participants. In addition, the varied ways different forms of theories are integrated within personal paradigms reflects the complexity of service-users' needs in the public mental health system. It also demonstrates a multiplicity of approaches is required to resolve service-users' occupational issues.

The recommendations from the study are described below.

Occupation-Focused Models

- **It is recommended practitioners use occupation-focused models conceptually and instrumentally in practice. These models can guide and maintain occupation-based practice in mental health workforces.**

The study supports the notions that the use of occupation-focused models allows practitioners to acquire an in-depth understanding of what is happening to service users as a consequence of their mental health issues, and why, and how best to address their occupational issues (Lee et al. 2012; Turpin & Iwama 2011). The use of an occupation-focused model in practice helps focus interventions on service-users' occupational issues. Without this orientation occupational issues may become less prioritized and the practitioner may focus on biomedical and psychological needs. When these models are used in practice they can play a key part in reducing the frustration occupational therapists experience when explaining what underpins practice. This is because the vocabulary from occupation-focused models offers practitioners a means of explaining to others the dynamic interaction between people, their occupations, and their environments, and how these guide practical actions (Kinsella & Whiteford 2009).

The study identified that in mental health practice, if occupation-focused models are only used tacitly and conceptually in tandem with psychological frames of reference, the focus on occupational issues can be lost. This is because while a practitioner's conceptual use of occupation-focused models identifies a service-user's occupational issues, unless these models are used instrumentally, these issues may not remain the focus of practice.

- **It is recommended practitioners use supervision to directly reflect on the impact and role of occupation-focused models in their professional reasoning.**

The study highlights that unless practitioners use formal supervision time to overtly reflect on their practice, they are not always able to identify the workings of occupation-focused models in their clinical practice. If practitioners do not have time to reflect on how they value and use

different forms of theoretical knowledge, this can add to the difficulties occupational therapists experience in explaining their roles and practical actions to others (Duffy & Nolan 2005; Fortune & Fitzgerald 2009). This difficulty is intensified when occupation-focused models are used tacitly and conceptually. The supervision process needs to be in place during the transition into practice, because the findings illustrated occupation-focused models may be embedded into the tacit dimension of phronesis in early career stages.

- The introduction of occupation-focused models in practice requires careful consideration and planning—to overcome habituated practice.

This may require structured continuing professional development (CPD) workshops with follow-up and continued support on their applications in practice. The findings also demonstrated that, to appeal to practitioners' pragmatic nature, CPD should evidence the efficacy of occupation-focused models' instrumental uses in practice (Hooper & Wood 2002). This recommendation comes from the study finding practitioners prefer to use the occupation-focused model with which they are most familiar. When they have a choice, they use an habituated model over other less familiar models, or newer versions of their currently used model. This indicates it may be difficult for more recently developed occupation-focused models, to be introduced into practice.

Psychological Frames of Reference

- It is recommended if occupational therapists use psychological frames of reference and their associated therapies, they be adapted to include occupation-based practice. This is a necessary step in ensuring service-users' occupational needs are addressed. This step

requires critical reflection on the implications of that use on practical actions.

The study demonstrated the importance of adapting psychological frames of reference and associated therapies to maintain the focus on the service-users' occupational issues. This study found a reliance on frames of reference from psychology, even with judicious translation and adaptation to meet occupational issues, may lead to the adoption of treatment methods lacking an occupation-focus. This contributes to diminished professional identity and visible occupation-based interventions noted by (Pettican & Bryant 2007). The participants indicated the incorporation of psychological theories and therapies by mental health occupational therapists often diminished occupational issues.

The need for more critical reflection on the use of psychological frames of reference, by occupational therapists in mental health practice, is needed because their use is commonplace and a social norm. The overuse of these psychological frames of reference can create a dissonance with occupation-based practice. The findings suggest that while psychological therapies can contribute to a professional toolbox, the ability to balance and adapt these therapies to include occupation maintains professional identity and professional resilience. The findings indicated this balance is enhanced by the conceptual and instrumental use of occupation-focused theoretical knowledge.

The study indicated there is a need for occupational therapists to critically debate how psychological frames of reference and their associated therapies impact on occupation-based practice in different contexts. While it is important for individual practitioners to critically reflect on practice, this debate needs to occur at all levels of the profession. The findings from the study suggest it may be timely, at a macrolevel, to further explore how the use of psychological therapies is presented in occupational therapy

literature and practice. The study indicates the need for a similar debate to the one initiated by Friedland (1998), into the use of rehabilitation models by occupational therapists. In mental health practice more critical debate about the potential dissonance caused by this use of psychological frames of reference may challenge the accepted use of these theories as complementary to occupational therapists' practice in mental health. Further debate on this issue may lead to a change in the socionorms in the profession and workplaces by questioning the traditional acceptance of the use of psychological frames of reference and associated therapies. The study showed over time, the use of psychological frames of reference might impact on professional identity. To consolidate their role and professional identity in mental health practice occupational therapists may need to more fully appreciate the value of their occupation focus.

Recommendations for Research

As revealed in the literature review there is relatively little research into the theoretical knowledge use of occupational therapists. The study's findings have highlighted the need for further exploration of this topic because it has an impact on professional identity and on the occupational orientation of practice initiatives.

Further Research into the Integration of Theoretical Knowledge in Curricula

In occupational therapy the nexus between educational curricula and practice requires more study. While previous survey-based studies have identified occupation-focused models are included in curricula (Ashby & Chandler 2010), there is a need for further research into the best teaching strategies for integrating occupation-focused models into curricula.

Educational research into the most effective teaching strategies for the inclusion of occupation-focused models in entry-level curricula, and in CPD could integrate survey and qualitative research methodologies. The identification of the most effective teaching strategies could improve the confidence of graduates to use occupation-focused models more explicitly and instrumentally to guide occupation-based practice. This would be a useful direction for educational research because curricula content plays an important role in the use of theoretical knowledge in practice.

Further Research into the Impact of Discourse Dimensions in Mental Health Practice

There is a need for further research in mental health practice into the impact of the two discourse dimensions identified in this study: the dominant discourse dimension, and practice knowledge in workplaces. It is important to research how these discourses impact on the occupational therapy community. Mixed methods research combining survey methods and interviews could effectively explore practitioners' perceptions about the effectiveness of strategies used to counter these discourses at the microlevel.

Further Research into Professional Resilience

A further direction for research is the investigation of the effectiveness of curricula in establishing graduates' professional identity and resilience. There is a need to use mixed-methods research to find the most effective teaching strategies to develop professional resilience within entry-level programs. This study is the first to identify the influence of the relationship between the use of theoretical knowledge, professional identity and occupation-based practice on practitioners' professional resilience. This dynamic requires further investigation.

The offering of professional supervision, and the development of professional networking, may be key in the maintenance of professional resilience for those within the occupational therapy mental health workforce. A greater understanding of the issues strengthening and challenging professional identity can assist educators and managers to better prepare graduates to transition into practice, and develop strategies to increase retention of experienced practitioners. This study also highlighted the need for research into the factors, which impact on professional resilience during graduates' transition into practice. This research should focus on the impact of the practice knowledge discourse dimension.

Establishing why occupational therapists leave the profession may also further assist in developing strategies to maintain professional resilience and improve retention in the workforce.

Further Research into the Use of Occupation-Focused Models in Mental Health Practice

The study highlighted the need for further qualitative studies into the effectiveness of using occupation-focused models in mental health practice contexts. This is important, as practitioners need evidence to support their choice of interventions before adopting occupation-focused models, and occupation-based practices. The extensive research evidence-base of psychological frames of reference often leads to the use of psychological therapies over occupation-based practice.

While this study gained some insight into practitioners' tacit use of theoretical knowledge in professional reasoning, and what influences their choice of theoretical knowledge, more qualitative research is required to better understand the processes through which practice knowledge progresses and its impact on practical actions. Research into this process

could track the familiarity of occupational therapy students with occupation-focused models and explore whether implicit curricula is influential. This could take the form of research into the impact of practice education experiences on practitioners' future use of different forms of theoretical knowledge.

Ethnographic research methodologies would allow observation of the use of occupation-focused models in practice settings. In this type of study researchers are then able to interview participants and observe the ways in which participants integrate theoretical knowledge in phronesis.

Following CPD events about occupation-focused models post workshop surveys and semi-structured interviews could identify the facilitators and barriers to their implementation in practice. This could also identify the most effective ways of introducing practitioners to different occupation-focused models.

The effectiveness of different supervision styles in supporting the use of occupation-focused models requires further research. In general, there is a lack of research into practitioners' experience of professional supervision in occupational therapy practice. Qualitative research methodologies can be used to explore what aspects of supervision are required to make supervision effective.

Further Research into Use of Psychological Frames of Reference in Mental Health Practice

It is important occupational therapists critically review and research the ways the use of psychological frames of reference and associated therapies can impact on occupation-based practice. Given the impact of psychological frames of reference on occupational therapy practice directions, further studies are needed: (i) into the ways in which

practitioners' apply this knowledge in practice (ii) to develop a critical review of the way psychological theories impact on occupation-based practice, and (iii) to study the effectiveness of combining them with occupation-focused models in mental health practice to resolve service-users' occupational issues. This research would add to the debate regarding the appropriation of borrowed theoretical knowledge into an occupational therapist's professional toolbox.

Limitations of the Study

The literature and research on practice knowledge is diverse and allows for the use of many different theoretical perspectives. The choice to use Bronfenbrenner's (1979) social ecological model was made because it lent itself to the analysis of the influences which differing social environmental factors had on the value and use of theoretical knowledge by occupational therapists'. Nevertheless, the study could have analysed the data from many other perspectives, such as the perspectives of Bourdieu and Passeron's (1977) on cultural capital within professional groups and this is acknowledged as a limitation of the analysis presented in this thesis. Similarly, while Foucault's descriptions of the power/knowledge (1980) discourses within professional groupings informed the analysis of relationships between the discourses this was not the focus of the analysis.

The choice to use occupational therapists working in one area's Mental Health Service was made for pragmatic and conceptual reasons: although it contextualised the study in a geographical area, participants' experienced macrolevel social environments were determined by similar policies at a State, Regional, and Service level. Although the literature review identified common issues facing occupational therapists in mental health practitioners in different locations may be likely to experience different organisational pressures. This may limit the transferability of the findings

in services that determine the adoption of one occupation-focused model by those working in particular services.

The choice to explore theoretical knowledge use among practitioners with experience of more than one mental health practice setting enabled participants to compare and contrast the knowledge used in different settings, and the similarities or differences of influence from one workplace to another. While this provided rich data for analysis it did result in the exclusion of practitioners with less than two years' experience. As noted in the methodology this was based on findings from previous studies on occupational therapy graduates' preparedness for practice, which found those with less than two years' experience, in all practice settings, tended to be more focused on consolidation of their practical skills rather than on the use of theoretical knowledge (Hodgetts et al. 2007; Quick, Forsyth & Melton 2007). The exploration of the transition period is acknowledged as falling outside of the transferability of the study and is an area that requires further research.

Narrative inquiry and narrative thematic analysis placed the use of theoretical knowledge in the context of professional histories. However, while the chosen methodology allowed theoretical knowledge use to be uncovered it is acknowledged that other qualitative methodologies could also be successfully used to discover more about the theory practice nexus. A narrative thematic analysis (Reissman 2008; Wengraf 2001) allowed for the emergence and identification of commonalities and differences across professional histories. However, other forms of narrative analysis could also have been used to uncover the plots and roles taken by occupational therapists in mental health practice (Roemer 1995).

Conclusion

The study identified Bronfenbrenner's (1979) social ecological model can underpin discussions may shape how the macro, meso and microlevels on practitioners' use of different forms of theoretical knowledge in practice. The study led to a greater understanding of the power relationships within mental health workplaces experienced by practitioners and the potential influence of the dominant discourse and practice knowledge dimensions. Understanding the impact of the multifaceted nature of the tension experienced by practitioners at the macro, meso and microlevels explains the resultant spectrum of personal paradigms. This study has shed light on how the value and use of theoretical knowledge is influenced by these discourses, and on how practitioners use of occupation-focused models can play a role in their coping with the tensions which exist in mental health practice whilst remaining occupationally oriented.

The study identified that people in education and leadership positions can play important roles in supporting the occupational therapy practitioners at macro, meso and microlevels. Managers and other leaders within communities of practice can instigate monthly professional meetings and other strategies, which can shape occupation-based service provision, and which lead to the recruitment and retention of experienced occupational therapy staff in mental health services. In this research, professional socialisation mechanisms were invaluable to practitioners isolated in teams, because socialisation assists practitioners to deal with the frustrations of being minority members of multidisciplinary and interprofessional teams. Educators can instil confidence in identifying the evidence supporting occupation-based practice, and in the efficacy of the professional paradigm and overarching connections between occupation and health.

The study identified the protective strategies used by experienced practitioners to maintain their professional resilience. It has also contributed to a deeper understanding of the factors affecting practitioners' use of different forms of theoretical knowledge. It demonstrates the ways in which experienced occupational therapists, in mental health settings, combine theoretical, factual, professional, and personal knowledge as they attempt to negotiate the gap between theory and practice. It highlights that while occupation-focused models are used tacitly and conceptually in mental health occupational therapy practice, there appears to be a need to increase instrumental use.

The study established there is a need for a more critical review of the use of borrowed theories in practice because when occupational therapists use psychological frames of reference and therapies explicitly, this often creates dissonance between occupational issues and outcomes. This can lead to a negative impact on practitioners' professional identity, resilience, and roles. This highlights the need for a more nuanced, adaptive way to use psychological frames of reference in practice to ensure practitioners work with service users to resolve occupational issues. The occupational adaption of therapies derived from psychology is a necessary step to ensure practice remains occupationally focused. The consequences of the exclusion of this step require further investigation with the findings indicating that it causes occupation-based practices to become marginalised. Their use in practice is also linked to the value practitioners place on psychological frames of reference if they are considered as more efficacious, and of greater clinical utility, than those drawn from the occupational therapy professional paradigm.

REFERENCES

- Aiken, FE, Fourn, AM, Cheng, IKS & Polatajko, HJ 2011, 'The meaning gap in occupational therapy: Finding meaning in our own occupation', *Canadian Journal of Occupational Therapy*, vol. 78, no. 9, pp. 294-302.
- Allen, CK 1985, *Occupational therapy for psychiatric diseases: measurement and management of cognitive disabilities*, Little, Brown and Company, Boston.
- American Psychological Association 2000, *The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) - Revised* 4th edn, American Psychological Association, Washington DC.
- Anthony, WA 1993, 'Recovery from mental illness: The guiding vision of the mental health service system in the 1990s', *Psychiatric Rehabilitation Journal* vol. 16, no. 4, pp. 11-23.
- Argyris, C & Schon, D 1974, *Theory in practice: Increasing professional effectiveness*, Jossey-Bass Publishers, San Francisco.
- Ashby, SE 2000, 'Walking the walk, talking the talk - applying theory in practice', *College of Occupational Therapists*.
- Ashby, SE 2008, 'Use of the Model of Human Occupation's assessment tools in mental health practice - Invited Speaker', *Greater Western Health Authority*
- Ashby, SE 2010a, 'Professional journeys in mental health: Developing professional resilience', in *15th World Federation of Occupational Therapy Congress*, Santiago, Chile.
- Ashby, SE 2010b, 'The theoretical knowledge valued and used by experienced occupational therapists working in mental health practice', *15th World Federation of Occupational Therapy Congress*.
- Ashby, SE 2011a, 'Exploring how occupational therapists use theoretical knowledge in mental health practice', *COT Annual Conference*.
- Ashby, SE 2011b, 'Exploring the theoretical knowledge used in mental health practice', *COT Annual Conference*.
- Ashby, SE & Chandler, B 2010, 'An exploratory study of the occupation-focused models included in occupational therapy professional

Appendices

- education programmes', *British Journal of Occupational Therapy*, vol. 73, no. 12, pp. 616-624.
- Ashby, SE, Gray, M & Ryan, S 2012, 'Professional resilience for occupational therapists in psycho-social practice', in *Canadian Association of Occupational Therapy*, Quebec City.
- Ashby, SE, Ryan, S, Gray, M & James, CL 2013, 'Factors that influence the professional resilience of occupational therapists in mental health practice', *Australian Occupational Therapy Journal*, vol. 60, no. 2, pp. 110-119.
- Australian Bureau of Statistics, *UNIT GROUP 2383 OCCUPATIONAL THERAPISTS*. [2 June 2010].
- Australian Health Ministers 2003, *National Mental Health Plan 2003-2008*, Australian Government Publishing Service, Canberra, Australia.
- Australian Institute of Health and Welfare 2001, *Occupational Therapy Labour Force 1998*, Department of Health and Ageing, Government of Australia, Canberra, ACT.
- Australian Institute of Health and Welfare 2006, *Occupational Therapy Labour Force 2002-2003*, Department of Health and Ageing, Australian Government., Canberra, ACT.
- Banks, S, Bell, E & Smits, E 2000, 'Integration tutorials and seminars: Examining the integration of academic and fieldwork learning by student occupational therapists ', *Canadian Journal of Occupational Therapy*, vol. 67, no. 2, pp. 93-100.
- Barris, R & Kielhofner, G 1985, 'Generating and using knowledge in occupational therapy: Implications for professional education.', *Occupational Therapy Journal of Research*, vol. 5, no. 2, pp. 113-124.
- Bartlow, P & Hartwig, C 1989, 'Status of practice in mental health: Assessment and frames of reference', *Australian Occupational Therapy Journal* vol. 36, no. 4, pp. 180-192.
- Bazeley, P 2007, *Qualitative Data Analysis with NVivo*, Sage Publications Limited, London.
- Beck, AT 1976, *Cognitive therapy and the emotional disorders*, Meridian, New York.
- Beck, AT, Rush, AJ, Shaw, BF & Emery, G 1979, *Cognitive therapy of depression*, Guildford Press, New York.
- Beck, J 1995, *Cognitive therapy: Basics and beyond*, Guildford Press, New York.

Appendices

- Bennett, S, Tooth, L, McKenna, C, Rodger, S, Strong, J, Ziviani, J, Mickan, S & Gibson, L 2003, 'Perceptions of evidence-based practice: A survey of Australian occupational therapists', *Australian Occupational Therapy Journal* vol. 50, no. 1, pp. 13-22.
- Bernstein, B 2000, *Pedagogy, symbolic control and identity: Theory, research, critique*, Revised edn, Rowman and Littlefield Publishers Inc., Lanham, Maryland.
- Björklund, A 1994, 'Occupational therapist: A chameleon in the light of paradigms', *Scandinavian Journal of Occupational Therapy*, vol. 1, no. 2, pp. 59-68.
- Björklund, A 1999, 'Focus on occupational therapists' paradigms', *Scandinavian Journal of Caring Sciences* vol. 13, no. 3, pp. 165-170.
- Björklund, A 2000, 'Occupational therapy students' paradigms: A passage from beholder to practitioner', *Australian Occupational Therapy Journal* vol. 47, no. 3, pp. 97-109.
- Björklund, A & Svensson, T 2006, 'A longitudinal study on the transformation of fifteen occupational therapist students' paradigms into occupational therapists' paradigms. ', *Australian Occupational Therapy Journal* vol. 53, no. 2, pp. 87-97.
- Blesedell Crepeau, E, Cohn, E, S. & Schell, BAB (eds) 2009, *Willard and Spackman's Occupational Therapy*, 11th edn, Wolters Kluwer/Lippincott Williams & Wilkins, Philadelphia, PA.
- Boniface, G, Fedden, T, Hurst, H, Mason, M, Phleps, C, Reagon, C & Waygood, S 2008, 'Using theory to underpin an integrated occupational therapy service through the Canadian Model of Occupational Performance', *British Journal of Occupational Therapy*, vol. 71, no. 12, pp. 531-539.
- Bonney, S & Stickley, T 2008, 'Recovery and mental health: A review of the British Literature', *Journal of Psychiatry and Mental Health Nursing*, vol. 15, no. 2, pp. 140-153.
- Bourdieu, P & Passeron, JC 1977, *Reproduction in education, society and culture*, Sage, London.
- Bowling, A 1997, *Research methods: Investigating health and health services*, Open University Press, Buckingham.
- Brintnell, E, Haglund, L, Larson, A & Piergrossi, J 2005, 'Occupational therapy in mental health today: A survey and some reflections', *WFOT Bulletin*, vol. 52, pp. 9-16.

Appendices

- Bronfenbrenner, U 1979, *The ecology of human development: Experiments by nature and design*, Harvard University Press, Cambridge, MA.
- Brown, B, Crawford, P & Darongkamas, J 2000, 'Blurred roles and permeable boundaries: The experience of multidisciplinary working in community mental health', *Health and Social Care in the Community*, vol. 8, no. 6, pp. 425-435.
- Brown, G, Esdaile, S.A., Ryan, S. E. (ed.) 2003, *Becoming an advanced healthcare practitioner*, Butterworth and Heinemann., Oxford.
- Brown, K, James, C & Mackenzie, L 2006, 'The practice placement education experience: An Australian pilot study exploring the perspectives of health professional students with a disability ', *British Journal of Occupational Therapy*, vol. 69, no. 1, pp. 31-37.
- Bullock, A & Bannigan, K 2011, 'Effectiveness of Activity-Based Group Work in Community Mental Health: A Systematic Review', *American Journal of Occupational Therapy May/June*, vol. 65, no. 3, pp. 257-266.
- Canadian Association of Occupational Therapists 1997, *Enabling occupation*, CAOT Publications, Ottawa, ON.
- Canadian Association of Occupational Therapists 2002, *Enabling occupation: An occupational therapy perspective*, Revised edn, CAOT Publications ACE, Ottawa, ON.
- Carr, SM 2005, 'Knowing nursing - the challenge of articulating knowing in practice', *Nurse Education in Practice*, vol. 5, no. 6, pp. 333-339.
- Ceramidas, DM 2010, 'A case against generalisation of mental health occupational therapy in Australia', *Australian Occupational Therapy Journal*, vol. 57, no. 6, pp. 409-416.
- Ceramidas, DM, Forn de Zita, C, Eklund, M & Kirsh, B 2009, 'The 2009 world team of mental health occupational therapists: A resilient and dedicated workforce', *WFOT Bulletin*, vol. 60, pp. 9-17.
- Chapparo, C & Ranka, J 1997, *Occupational performance model (Australia): Monograph 1*, OP Network, Sydney, Australia.
- Christiansen, C & Baum, C 1997, 'Person - environment - occupational performance: A conceptual model for practice', in *Occupational therapy: enabling function and well-being*, eds CH Christiansen & CM Baum, Slack, Thorofare, NJ, pp. 46-70.
- Clandinin, DJ & Connelly, FM 2000, *Narrative inquiry: Experience and story in qualitative research*, Jossey-Bass Inc. Publishers, San Francisco.

Appendices

- Clinton, M & Hazelton, M 2002, 'Towards a Foucauldian reading of the Australian mental health nursing workforce', *International Journal of Mental Health Nursing* vol. 11, no. 1, pp. 18-23.
- Coffey, A & Atkinson, P 1996, *Making sense of qualitative data: Complementary research strategies*, Sage Publications Ltd, Thousand Oaks, Ca.
- Commonwealth Department of Health and Ageing 2011, *Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule (Better Access) initiative*, Department of Health and Ageing, Australian Government, Canberra, ACT.
- Commonwealth of Australia 2009, *National Mental Health Strategy 2008*, Commonwealth of Australia, Barton, ACT.
- Conte, JR & Conte, WR 1977, 'The use of conceptual models in occupational therapy', *American Journal of Occupational Therapy*, vol. 31, no. 4, pp. 262-265.
- Cook, S, Chambers, E & Coleman, JH 2009, 'Occupational therapy for people with psychotic conditions in community settings: A pilot randomized controlled trial', *Clinical Rehabilitation*, vol. 23, no. 1, pp. 40-52.
- Cornelissen, E, Mitton, C & Sheps, S 2011, 'Knowledge translation in the discourse of professional practice', *International Journal of Evidence-Based Healthcare*, vol. 9, no. 2, pp. 184-188. Available from: a9h.
- Craik, C, Chacksfield, JD & Richards, G 1998, 'A survey of occupational therapy practitioners in mental health', *British Journal of Occupational Therapy*, vol. 61, no. 5, pp. 227-234.
- Creek, J 2003, *Occupational therapy defined as a complex intervention*, College of Occupational Therapists, London.
- Creek, J & Feaver, S 1993, 'Models for practice in occupational therapy: Part 1, defining terms', *British Journal of Occupational Therapy*, vol. 56, no. 1, pp. 4-6.
- Creek, J & Lougher, L (eds) 2008, *Occupational therapy and mental health* 4th edn, Churchill Livingstone Elsevier, Edinburgh.
- Cusick, A 2001, 'OT OT EBP 21C: Australian occupational therapy evidence-based practice and the 21st century', *Australian Occupational Therapy Journal* vol. 48, no. 3, pp. 102-117.
- Cutcliffe, J & Happell, B 2009, 'Psychiatry, mental health nurses, and invisible power: Exploring a perturbed relationship within contemporary mental health care', *International Journal of Mental Health Nursing*, vol. 18, no. 2, pp. 116-125.

Appendices

- Darlington, Y & Scott, D (eds) 2002, *Qualitative research in practice; Stories from the field*, Allen & Unwin Sydney.
- de Cossart, L & Fish, D 2005, *Cultivating a thinking surgeon: New perspectives on clinical teaching, learning, and assessment*, tfm Publishing Ltd, Shrewsbury.
- de Shazer, S 1988, *Investigating solutions in brief therapy*, W.W. Norton and Company, New York.
- Deegan, PE 1996, 'Recovery as a journey of the heart', *Psychiatric Rehabilitation Journal*, vol. 19, no. 3, pp. 91--97.
- Delanty, G 2001, *Challenging knowledge: The university in the knowledge society*, The Society for Research into Higher Education & Open University Press, Philadelphia, PA.
- Denzin, N & Lincoln, YS 1994, *Handbook of qualitative research*, Sage Publications, Thousand Oaks.
- Denzin, N & Lincoln, YS 2005, *Handbook of qualitative research*, 3rd edn, Sage Publications, Thousand Oaks.
- DeSantis, L & Ugarriza, D 2000, 'The concept of theme as used in qualitative nursing research', *Western Journal of Nursing Research* vol. 22, no. 3, pp. 351-372.
- Dingwall, R 2008, 'In the beginning was the Work...Reflections on the genesis of occupations', in *Essays on professions*, ed. R Dingwall, Ashgate Publishing Limited, Aldershot, Hampshire, pp. 45-60.
- Doherty, G, Stagnitti, K & Schoo, A 2009, 'From student to therapist: follow up of a first cohort of Bachelor of Occupational Therapy students.', *Australian Occupational Therapy Journal*, vol. 56, pp. 341-349.
- Duffy, R & Nolan, P 2005, 'A survey of the work of occupational therapists in inpatient mental health services', *Mental Health Practice*, vol. 8, no. 6, pp. 36-41.
- Duncan, E (ed.) 2006, *Foundations for practice in occupational therapy*, 4th edn, Elsevier Churchill Livingstone, Philadelphia, PA.
- Dunn, W, Brown, C & McGuigan, A 1994, 'The ecology of human performance: A framework for considering the effect of context', *American Journal of Occupational Therapy*, vol. 48, no. 7, pp. 595-607.
- Dybicz, P 2004, 'An inquiry into practice wisdom', *Families in Society: The Journal of Contemporary Social Services*, vol. 85, no. 2, pp. 197-203.
- Edgar, A 2006, *Habermas: The key concepts*, Routledge, Hoboken, NJ.

- Edward, K-L 2005, 'The phenomenon of resilience in crisis care mental health clinicians', *International Journal of Mental Health Nursing*, vol. 14, no. 2, pp. 142-148.
- Egan, M 2003, 'Models and evidence-based practice: You can't have one without the other', *Canadian Journal of Occupational Therapy*, vol. 70, no. 5, pp. 261-265.
- Eklund, M 2002, 'Explicit and implicit methods in psychosocial occupational therapy ', *Occupational Therapy in Mental Health*, vol. 18, no. 2, pp. 3-15.
- Eklund, M & Leufstadius, C 2007, 'Relationships between occupational factors and health and well-being in individuals with persistent mental illness living in the community', *Canadian Journal of Occupational Therapy*, vol. 74, no. 4, pp. 303-313.
- Elliott, SJ, Velde, BP & Wittman, P 2002, 'The use of theory in everyday practice: An exploratory study', *Occupational Therapy in Health Care*, vol. 16, no. 1, pp. 45-62.
- Ennals, P & Fossey, E 2007, 'The Occupational Performance History Interview in community mental health case management: Consumer and occupational therapist persepectives', *Australian Occupational Therapy Journal*, vol. 54, no. 1, pp. 11-21.
- Eraut, M 1994, *Developing professional knowledge and competence*, Falmer Press, London.
- Eraut, M 2000, 'Non-formal learning and tacit knowledge in professional work ', *British Journal of Educational Psychology*, vol. 70, no. 1, pp. 113-136.
- Eraut, M 2007, 'Learning from other people in the workplace', *Oxford Review of Education*, vol. 33, no. 4, pp. 403-422.
- Ewert, GD 1991, 'Habermas and education: A comprehensive overview of the influence of Habermas on educational literature', *Review of Educational Research*, vol. 61, no. 3, pp. 345-378.
- Fargion, S 2007, 'Theory and practice: A matter of words, language, knowledge and professional community in social work ', *Social Work and Society*, vol. 5, no. 1, pp. 62-77.
- Farhall, J, Fossey, E, Keeble-Devlin, B, Meadows, G, Roberts, S & Singh, B 2007, 'Conceptual models used in mental health practice', in *Mental health in Australia: Collaborative community practice*, 2nd edn, eds G Meadows, B Singh & M Grigg, Oxford University Press, South Melbourne, pp. 23-50.

Appendices

- Fidler, AG 1996, 'Life-style performance: From profile to conceptual model', *American Journal of Occupational Therapy*, vol. 50, no. 2, pp. 139-147.
- Fink-Samnick, E 2009, 'The professional resilience paradigm: Defining the next dimension of professional self-care', *Professional Case Management*, vol. 14, no. 6, pp. 330-2.
- Finlay, L 1998, 'Reflexivity: An essential component for all research?', *British Journal of Occupational Therapy*, vol. 61, no. 10, pp. 453-456.
- Finlay, L 2004, *The practice of psychosocial occupational therapy*, 3rd edn, Nelson Thornes, Cheltenham.
- Fish, D 1998, *Appreciating practice in the caring professions*, Butterworth Heinemann, Oxford.
- Fish, D & Coles, C 2005, *Medical Education : Developing a curricula for practice*, Open University Press in Association with McGraw-Hill, Maidenhead,.
- Fleming, MH 1991a, 'Clinical reasoning in medicine compared with clinical reasoning in occupational therapy', *The American Journal of Occupational Therapy*, vol. 45, no. 11, pp. 988-996.
- Fleming, MH 1991b, 'The therapist with the three track mind', *The American Journal of Occupational Therapy*, vol. 45, no. 11, pp. 1007-1014.
- Forsyth, K, Summerfield Mann, L & Kielhofner, g 2005, 'Scholarship of practice: Making occupation-focused, theory-driven, evidence based practice a reality', *British Journal of Occupational Therapy*, vol. 68, no. 6, pp. 260-268.
- Fortune, T 2000, 'Occupational therapists: Is our therapy truly occupational or are we merely filling gaps?', *British Journal of Occupational Therapy*, vol. 63, no. 5, pp. 225-230.
- Fortune, T & Fitzgerald, M, H. 2009, 'The challenge of interdisciplinary collaboration in acute psychiatry: Impacts on the occupational milieu.', *Australian Occupational Therapy Journal* vol. 56, no. 2, pp. 81-88.
- Foucault, M 1980, *Michel Foucault. Power/knowledge: Selected interviews and other writings, 1972-1977.*, Harvester Press, Brighton.
- Friedland, J 1998, 'Occupational therapy and rehabilitation: An awkward alliance', *American Journal of Occupational Therapy*, vol. 52, no. 5, pp. 373-381.
- Gibbs, G 2007, *Analyzing qualitative data*, Sage Publications, Los Angeles.

Appendices

- Gibson, RW, D'Amico, M, Jaffe, L & Arbesman, M 2011, 'Occupational therapy interventions for recovery in the areas of community integration and normative life roles for adults with serious mental illness: A Systematic review', *American Journal of Occupational Therapy* vol. 65, no. 3, pp. 247-256.
- Gliner, JA 1994, 'Reviewing qualitative research: Proposed criteria for fairness and rigor', *Occupational Therapy Journal of Research*, vol. 14, no. 2, pp. 78-90.
- Gordon, DM 2009, 'The history of occupational therapy', in *Willard and Spackman's Occupational Therapy*, 11th edn, eds E Blesedell Crepeau, E Cohn, S. & BAB Schell, Wolters Kluwer/Lippincott Williams & Wilkins, Philadelphia, PA.
- Gray, M 2010, 'Writing and moral conundrums: Writing about morals and ethics and about them as subtext in articles with another focus'.
- Gray, M, Clark, M, Penman, M, Smith, J, Bell, J, Thomas, Y & Trevan-Hawke, J 2012, 'New graduate occupational therapists feelings of preparedness for practice in Australia and Aotearoa/New Zealand', *Australian Occupational Therapy Journal*, vol. Online.
- Greber, C 2011, 'Pluralism: Signposting a split in occupational therapy?', *Australian Occupational Therapy Journal*, vol. 58, no. 6, pp. 455-457.
- Griffin, S 2001, 'Occupational therapists and the concept of power: A review of the literature', *The Australian Occupational Therapy Journal* vol. 48, no. 1, pp. 24-34.
- Guba, E & Lincoln, Y 1984, 'Competing paradigms in qualitative research', in *Handbook of qualitative research* eds N Denzin & Y Lincoln, Sage, Thousand Oaks, California.
- Gunnarsson, AB & Eklund, M 2009, 'The Tree Theme Method as an intervention in psychosocial occupational therapy: Client acceptability and outcomes', *The Australian Occupational Therapy Journal* vol. 56, no. 3, pp. 167-176.
- Habermas, J 1972, *Knowledge and human interests*, Heinemann Educational Books Limited, London.
- Haglund, L, Ekbaldh, E, Thorell, L-H & Hallberg, IR 2000, 'Practice models in Swedish psychiatric occupational therapy', *Scandinavian Journal of Occupational Therapy*, vol. 7, no. 3, pp. 107-113.
- Haglund, L & Kjellberg, A 1999, 'A critical analysis of the model of human occupation', *The Canadian Journal of Occupational Therapy*, vol. 66, no. 2, pp. 102-108.

Appendices

- Haitham, J 2009, 'A survey of burnout of the mental health occupational therapy staff in the Psychiatric Hospital, Bahrain', *British Journal of Occupational Therapy*, vol. 72, no. 10, pp. 458-464.
- Hammell, KW 2004, 'Dimensions of meaning in the occupations of daily life', *Canadian Journal of Occupational Therapy*, vol. 71, no. 5, pp. 296-305.
- Hammell, KW 2007, 'Client-centred practice: Ethical obligation or professional obfuscation?', *British Journal of Occupational Therapy*, vol. 70, no. 6, pp. 264-266.
- Hammell, KW 2009a, 'Sacred texts: A sceptical exploration of the assumptions underpinning theories of occupation', *Canadian Journal of Occupational Therapy*, vol. 76, no. 1, pp. 6-13.
- Hammell, KW 2009b, 'Self-care, productivity, and leisure, or dimensions of occupational experience? Rethinking occupational "categories"', *Canadian Journal of Occupational Therapy*, vol. 76, no. 2, pp. 107-114.
- Harries, P 1998, 'Community mental health teams: Occupational therapists' changing role', *British Journal of Occupational Therapy*, vol. 61, no. 5, pp. 219-220.
- Harries, PA & Gilhooly, K 2003, 'Generic and specialist occupational therapy casework in community mental health teams', *British Journal of Occupational Therapy*, vol. 66, no. 3, pp. 101-109.
- Harrison, D 2003, 'The case for generic working in mental health occupational therapy', *British Journal of Occupational Therapy*, vol. 66, no. 3, pp. 110-112.
- Harrison, D 2005a, 'Context of change in community mental health occupational therapy: Part one', *International Journal of Therapy and Rehabilitation*, vol. 12, no. 9, pp. 396-400.
- Harrison, D 2005b, 'Context of change in community mental health occupational therapy: part one... including commentary by Lloyd C', *International Journal of Therapy & Rehabilitation*, vol. 12, no. 9, pp. 396-400. Available from: rzh.
- Harrison, D 2005c, 'Context of change in community mental health occupational therapy: part two... including commentary by Lloyd C, and Krupa T', *International Journal of Therapy & Rehabilitation*, vol. 12, no. 10, pp. 444-448. Available from: rzh.
- Hasselkus, BR 2002, *The meaning of everyday occupation*, Slack, Thorofare, NJ.
- Hayes, R, Bull, B, Hargreaves, K & Shakespeare, K 2008, 'A survey of recruitment and retention issues for occupational therapists

Appendices

- working clinically in mental health. ', *Australian Occupational Therapy Journal* vol. 55, no. 1, pp. 12-22.
- Hayes, S & Lillis, J 2012, *Acceptance and commitment therapy*, American Psychological Association, Washington DC.
- Higgs, J, Jones, M, Loftus, S & Christensen, N (eds) 2008, *Clinical reasoning in the health professions*, 3rd edn, Butterworth Heinemann Elsevier, Sydney.
- Higgs, J, Jones, M & Titchen, A 2008, 'Knowledge, reasoning and evidence for practice', in *Clinical reasoning in the health professions*, eds J Higgs, M Jones, S Loftus & n Christensen, Butterworth Heinemann Elsevier, Sydney, pp. 151-162.
- Higgs, J & Titchen, A (eds) 2001, *Practice knowledge and expertise in the health professions*, Butterworth and Heinemann, Oxford.
- Higgs, J, Titchen, A, Horsfall, D & Armstrong, H (eds) 2007, *Being critical and creative in qualitative research*, Hampden Press, Sydney.
- Hodges, HF, Keeley, AC & Grier, EC 2005, 'Professional resilience, practice longevity, and Parse's theory for baccalaureate education', *Journal of Nursing Education*, vol. 44, no. 12, pp. 548-554.
- Hodges, HF, Keeley, AC & Troyan, PJ 2008, 'Professional resilience in baccalaureate-prepared acute care nurses: First steps', *Nursing Education Perspectives*, vol. 29, no. 2, pp. 80-89.
- Hodgetts, S, Hollis, V, Triska, O & Dennis, S 2007, 'Occupational therapy students' and graduates' satisfaction with professional education and preparedness for practice', *Canadian Journal of Occupational Therapy*, vol. 74, no. 3, pp. 148-160.
- Holloway, I & Freshwater, D 2007, *Narrative research in nursing*, Blackwell Publishing, Oxford.
- Hooper, B 2006, 'Beyond active learning: A case study of teaching practices in an occupation-centred curriculum', *The American Journal of Occupational Therapy*, vol. 60, no. 5, pp. 551-562.
- Hooper, B 2008, 'Stories we teach by: Intersections among faculty biography, student formation, and instructional processes', *The American Journal of Occupational Therapy*, vol. 62, no. 2, pp. 228-241.
- Hooper, B & Wood, W 2002, 'Pragmatism and structuralism in occupational therapy: The long conversation', *American Journal of Occupational Therapy*, vol. 56, no. 1, pp. 40-50.

Appendices

- Hsiung, P 2008, 'Teaching reflexivity in qualitative interviewing', *Teaching Sociology*, vol. 26, pp. 211-216.
- Hughes, G 2001a, *Artistotle on ethics*, Routledge, London.
- Hughes, J 2001b, 'Occupational therapy in community mental health teams: A continuing dilemma? Role theory offers an explanation', *British Journal of Occupational Therapy*, vol. 64, no. 1, pp. 34-40.
- Ikiugo, M, N., Smallfield, S & Condit, C 2009, 'A framework for combining theoretical conceptual practice models in occupational therapy practice', *The Canadian Journal of Occupational Therapy*, vol. 76, no. 3, pp. 162-170.
- Ikiugu, M, N. 2007, *Psychosocial conceptual practice models in occupational therapy: Building adaptive capability*, Mosby Elsevier, St. Louis.
- Iwama, MK 2003, 'The issue is...toward culturally relevent epistemologies in occupational therapy', *American Journal of Occupational Therapy*, vol. 57, no. 5, pp. 217-223.
- Jackson, D, Firtko, A & Edenborough, M 2007, 'Personal resilience as a strategy for surviving and thriving in the face of workplace adversity: A literature review', *Journal of Advanced Nursing*, vol. 60, no. 1, pp. 1-9.
- Javetz, R & Katz, N 1989, 'Knowledgeability of theories of occupational therapy practitioners in Israel ', *The American Journal of Occupational Therapy*, vol. 43, no. 10, pp. 664-675.
- Jiwa, M, Chan, W, Ross, J, Shaw, T & Magin, PJ 2011, 'Communities of practice - quality improvement or research in general practice', *Australian Family Physician*, vol. 40, no. 1-2, pp. 72-75. Available from: rzh.
- Kelly, G & Mcfarlane, H 2007, 'Culture or cult? The mythological nature of occupational therapy', *Occupational Therapy International*, vol. 14, no. 4, pp. 188-202.
- Kielhofner, G 1992, *Conceptual frameworks in occupational therapy*, F.A. Davis, Philadelphia.
- Kielhofner, G 1997, *Conceptual frameworks in occupational therapy*, 2nd edn, F.A. Davis, Philadelphia.
- Kielhofner, G 2004, *Conceptual foundations of occupational therapy*, 3rd edn, F.A.Davis Co., Philadelphia, Pa.

Appendices

- Kielhofner, G 2007, 'Respecting both the "occupation" and the "therapy" in our field', *The American Journal of Occupational Therapy*, vol. 61, no. 4, pp. 479-482.
- Kielhofner, G 2008, *Model of human occupation: Theory and application*, 4th edn, Lippincott Williams & Wilkins, Baltimore.
- Kielhofner, G 2009, *Conceptual foundations of occupational therapy*, 4th edn, F.A.Davis Co., Philadelphia, Pa.
- Kielhofner, G & Burke, J 1977a, 'After 60 years: An account of changing identity and knowledge', *American Journal of Occupational Therapy*, vol. 31, no. 10, pp. 675-689.
- Kielhofner, G & Burke, J 1977b, 'Occupational therapy after 60 years: An account of changing identity and knowledge', *American Journal of Occupational Therapy*, vol. 31, no. 10, pp. 675-689.
- Kielhofner, G & Burke, J 1980, 'A model of human occupation, part 1: Conceptual framework and content', *The American Journal of Occupational Therapy*, vol. 34, no. 9, pp. 572-581.
- Kinn, LG & Aas, RW 2009, 'Occupational therapists' perception of their practice: A phenomenological study', *The Australian Occupational Therapy Journal* vol. 56, no. 2, pp. 112-121.
- Kinsella, EA & Pitman, A 2012, *Phronesis as professional knowledge: Practical wisdom in the professions*, Sense Publishers, Rotterdam.
- Kinsella, EA & Whiteford, GE 2009, 'Knowledge generation and utilisation in occupational therapy: Towards epistemic reflexivity', *Australian Occupational Therapy Journal* vol. 56, no. 4, pp. 249-258.
- Kitchenham, A 2008, 'The evolution of John Mezirow's Transformative Learning Theory', *Journal of Transformative Education*, vol. 6, no. 2, pp. 104-123.
- Kleinman, A 1988, *The illness narratives: suffering and healing, and the human condition*, Basic, New York.
- Kortman, B 1994, 'The eye of the beholder: Models in occupational therapy', *Australian Occupational Therapy Journal* vol. 41, no. 3, pp. 115-122.
- Krefting, L 1991, 'Rigor in qualitative research: the assessment of trustworthiness.', *American Journal of Occupational Therapy*, vol. 45, no. 3, pp. 214-222.
- Krefting, LH 1985, 'The use of conceptual models in clinical practice', *Canadian Journal of Occupational Therapy*, vol. 53, no. 4, pp. 173-178.

Appendices

- Krupa, T & Clark, C 2004, 'Occupational therapy in the field of mental health: Promoting occupational perspectives on health and well-being', *Canadian Journal of Occupational Therapy*, vol. 71, no. 2, pp. 69-74.
- Kuhn, T 1962, *The Structure of Scientific Revolutions*, University of Chicago Press, Chicago.
- Kvale, S 1996, *InterViews: An introduction to qualitative research interviews*, Sage Publications, Thousand Oaks.
- Lal, S 2010, 'Prescribing recovery as the new mantra for mental health: Does one prescription serve all?', *The Canadian Journal of Occupational Therapy*, vol. 77, no. 2, p. 82.
- Larkin, C & Callaghan, P 2005, 'Professionals' perceptions of interprofessional working in community mental health teams', *Journal of Interprofessional Care*, vol. 19, no. 4, pp. 338-346.
- Law, M, Cooper, B, Strong, S, Stewart, D, Rigby, P & Letts, L 1996, 'The person-environment-occupation model: A transactive approach to occupational performance', *Canadian Journal of Occupational Therapy*, vol. 63, pp. 186-192.
- Law, M & McColl, MA 1989, 'Knowledge and use of theory among occupational therapists: A Canadian survey', *Canadian Journal of Occupational Therapy*, vol. 56, no. 4, pp. 198-204.
- Lee, SW, Kielhofner, G, Morley, M, Heasman, D, Garnham, M, Willis, S, Parkinson, S, Forsyth, K, Melton, J & Taylor, RR 2012, 'Impact of using the Model of Human Occupation: A survey of occupational therapy mental health practitioners' perceptions', *Scandinavian Journal of Occupational Therapy*, vol. 19, no. 7, pp. 450-456.
- Lee, SW, Taylor, R & Kielhofner, G 2009, 'Choice, knowledge, and utilization of a practice theory: A national study of occupational therapists who use the Model of Human Occupation', *Occupational Therapy in Health Care*, vol. 23, no. 1, pp. 60-71.
- Lee, SW, Taylor, R, Kielhofner, G & Fisher, A, G 2008, 'Theory use in practice: A National survey of therapists who use the Model of Human Occupation', *American Journal of Occupational Therapy*, vol. 62, no. 1, pp. 106-117.
- Lees, A & Meyer, E 2011, 'Theoretically speaking: use of a communities of practice framework to describe and evaluate interprofessional education', *Journal of Interprofessional Care*, vol. 25, no. 2, pp. 84-90. Available from: rzh.

Appendices

- Lincoln, Y 1995, 'Emerging criteria for qualitative and interpretive research', *Qualitative Inquiry*, vol. 3, pp. 275-289.
- Lincoln, Y & Guba, E (eds) 1985, *Naturalistic inquiry*, Sage, Beverley Hills: CA.
- Lincoln, Y & Guba, E 2003, 'Paradigmatic controversies, contradictions, and emerging confluences', in *The landscape of qualitative research: Theories and issues*, 2nd edn, eds N Denzin & Y Lincoln, S., Sage, Thousand Oaks, CA, pp. 253-291.
- Linehan, MM, Schmidt, H, Dimeff, LA, Craft, JC, Kanter, J & Comtois, K 1999, 'Dialectical behaviour therapy for patients with borderline personality disorder and drug dependence', *American Journal of Addiction*, vol. 8, pp. 279-292.
- Lloyd, C, Bassett, H & King, R 2002, 'Mental health: How well are occupational therapists equipped for a changed practice environment? ', *Australian Occupational Therapy Journal* vol. 49, no. 3, pp. 163-166.
- Lloyd, C, Bassett, H & King, R 2004, 'Occupational therapy and evidence-based practice in mental health', *British Journal of Occupational Therapy*, vol. 67, no. 2, pp. 83-88.
- Lloyd, C & King, R 2004, 'A survey of burnout among Australian mental health occupational therapists and social workers', *Social Psychiatry and Psychiatric Epidemiology*, vol. 39, no. 9, pp. 752-757.
- Lloyd, C, King, R & Bassett, H 2002, 'A survey of Australian mental health occupational therapists', *British Journal of Occupational Therapy*, vol. 65, no. 2, pp. 88-96.
- Lloyd, C, King, R, McCarthy, M & Scanlan, M 2007, 'The association between leisure motivation and recovery: A pilot study', *Australian Occupational Therapy Journal* vol. 54, no. 1, pp. 33-41.
- Lloyd, C, King, R & McKenna, K 2004a, 'Actual and preferred work activities of mental health occupational therapists: Congruence or discrepancy?', *British Journal of Occupational Therapy*, vol. 67, no. 4, pp. 167-175.
- Lloyd, C, King, R & McKenna, K 2004b, 'Generic versus specialist clinical work roles of occupational therapists and social workers in mental health', *Australian and New Zealand Journal of Psychiatry*, vol. 38, no. 3, pp. 119-124.
- Lloyd, C, King, R & Ryan, L 2007, 'The challenge of working in mental health settings: Perceptions of newly graduated occupational

Appendices

- therapists', *British Journal of Occupational Therapy*, vol. 70, no. 11, pp. 460-470.
- Lloyd, C, McKenna, K & King, R 2004, 'Is discrepancy between actual and preferred work activities a factor in work-related stress for mental health occupational therapists and social workers?', *British Journal of Occupational Therapy*, vol. 67, no. 8, pp. 353-360.
- Lloyd, C, McKenna, K & King, R 2005, 'Sources of stress experienced by occupational therapists and social workers in mental health settings', *Occupational Therapy International*, vol. 12, no. 2, pp. 81-94.
- Lloyd, C, Waghorn, G & Williams, PL 2008, 'Conceptualising recovery in mental health rehabilitation', *British Journal of Occupational Therapy*, vol. 71, no. 8, pp. 321-328.
- Mackey, H 2007, 'Do not ask me to remain the same': Foucault and the professional identities of occupational therapists ', *Australian Occupational Therapy Journal* vol. 54, no. 2, pp. 95-102.
- MacKinnon, D & Coleborne, C 2003, 'Introduction: Deinstitutionalisation in Australia and New Zealand', *Health and History*, vol. 5, no. 2, pp. 1-16.
- Madigan, S 2010, *Narrative therapy*, American Psychological Association, Washington DC.
- Mattingly, C 1991a, 'The narrative nature of clinical reasoning', *The American Journal of Occupational Therapy*, vol. 45, no. 11, pp. 998-1005.
- Mattingly, C 1991b, 'What is clinical reasoning?', *The American Journal of Occupational Therapy*, vol. 50, no. 11, pp. 979-984.
- Mattingly, C 1994, 'The concept of therapeutic 'emplotment'', *Social Science and Medicine*, vol. 38, no. 6, pp. 811-822.
- Mattingly, C & Fleming, MH 1994, *Clinical forms of inquiry in a therapeutic practice*, F.A. Davis Company, Philadelphia.
- McGee, E 2006, 'The healing circle: Resiliency in nurses', *Issues in Mental Health Nursing*, vol. 27, no. 1, pp. 43-57.
- McLaughlin Gray, J 1998, 'Putting occupation into practice: Occupation as ends, occupation as means', *American Journal of Occupational Therapy*, vol. 52, no. 5, pp. 354-365.
- Meadows, G, Singh, B & Grigg, M (eds) 2007, *Mental health in Australia: Collaborative community practice*, 2nd edn, Oxford University Press, South Melbourne.

Appendices

- Melton, J 2006, 'Occupational therapists in action: An action research project to develop evidence based occupational therapy services and bridge the theory-practice gap. ', *14th World Federation of Occupational Therapy Congress*.
- Mental Health & Drug & Alcohol Office 2006, *NSW: A new direction for Mental Health*, NSWHealth, NSW Department of Health, North Sydney, NSW.
- Merton, RK 1963, *Social Theory and Social Structure*, Collier-Macmillan, London.
- Metzler, M, J. & Metz, G, A. 2010, 'Translating knowledge to practice: An occupational therapy perspective', *Australian Occupational Therapy Journal*, vol. 57, pp. 373-379.
- Mezirow, J 1991, *Transformative dimensions of adult learning.*, Jossey-Bass, San Francisco, CA.
- Milburn, PC & Colyer, H 2008, 'Professional knowledge and interprofessional practice', *Radiography*, vol. 14, no. 4, pp. 318-322.
- Miller, R, Sieg, KW, Ludwig, FM, Shortridge, SD & Van Deusen, J (eds) 1988, *Six perspectives on theory for the practice of occupational therapy*, Aspen Publishers Inc., Rockville, Maryland.
- Mills, CW 1959, *The Sociological Imagination*, Blackwell, Oxford.
- Minichiello, V, Arani, R, Timewell, E & Alexander, L 1990, 'Indepth Interviewing: Researching People'.
- Minichiello, V & Kottler, JA (eds) 2010, *Qualitative journeys: Student and mentor experiences with research*, Sage, Thousand Oaks, CA.
- Mocellin, G 1995, 'Occupational therapy: a critical overview, part 1', *British Journal of Occupational Therapy*, vol. 58, no. 12, pp. 502-506.
- Mocellin, G 1996, 'Occupational therapy: a critical overview, part 2', *British Journal of Occupational Therapy*, vol. 59, no. 1, pp. 11-16.
- Molineux, M 2011a, 'Standing firm on shifting sands', *New Zealand Journal of Occupational Therapy*, vol. 58, no. 1, pp. 21-28. Available from: rzh.
- Molineux, M 2011b, 'Standing firm on shifting sands.', *New Zealand Journal of Occupational Therapy*, vol. 58, no. 1, pp. 21-28. Available from: rzh.
- Molyneux, J 2001, 'Interprofessional teamworking: What makes teams work well?', *Journal of Interprofessional Care*, vol. 15, no. 1, pp. 29-35.

Appendices

- Morse, JM 2004, 'Constructing qualitatively derived theory: Concept construction and concept typologies', *Qualitative Health Research*, vol. 14, no. 10, pp. 1387-1397.
- Mosey, AC 1973, *Activities therapy*, Raven, New York.
- Mosey, AC 1981, *Occupational therapy: Configuration of a profession*, Raven Press, New York.
- Mosey, AC 1985, 'A monistic or a pluralistic approach to professional identity [Eleanor Clarke Slagle Lecture 1985]', *American Journal of Occupational Therapy*, vol. 39, no. 8, pp. 504-509.
- Mosey, AC 1986, *Psychosocial components of occupational therapy*, Raven Press, New York.
- Mullen, A 2009, 'Mental health nurses establishing psychosocial interventions within acute inpatient settings', *International Journal of Mental Health Nursing* vol. 18, no. 2, pp. 83-90.
- Nixon, J & Creek, J 2006, 'Towards a theory of practice', *British Journal of Occupational Therapy*, vol. 69, no. 2, pp. 77-80.
- Nolan, E & Hewison, A 2008, 'Teamwork in primary care mental health: A policy analysis', *Journal of Nursing Management*, vol. 16, no. 6, pp. 649-661.
- NSWHealth, NSW Mental Health Act. Available from: http://www.health.nsw.gov.au/policies/ib/2007/ib2007_053.html%3E.
- Nye, RA 2003, 'The evolution of the concept of medicalization in the late twentieth century', *Journal of History of the Behavioural Sciences*, vol. 39, no. 2, pp. 115-129.
- Nygren, L & Blom, B 2001, 'Analysis of short reflective narratives: A method for the study of knowledge in social workers' actions', *Qualitative Research*, vol. 1, no. 3, pp. 369-384.
- O'Neal, S, Dickerson, AE & Holbert, D 2007, 'The use of theory by occupational therapists working with adults with developmental disabilities', *Occupational Therapy in Health Care*, vol. 21, no. 4, pp. 71-85.
- Osmond, J 2005, 'The knowledge spectrum: A framework for teaching knowledge and its use in social work practice', *British Journal of Social Work*, vol. 35, no. 6, pp. 881-900.

- Osmond, J 2006, 'Knowledge use in social work practice: Examining its functional possibilities', *Journal of Social Work*, vol. 6, no. 3, pp. 221-237.
- Osmond, J & O'Connor, I 2004, 'Formalizing the unformalized: Practitioners' communication of knowledge in practice', *British Journal of Social Work*, vol. 34, no. 5, pp. 677-692.
- OT Australia 1994, *Australian Competency Standards for Entry-Level Occupational Therapists*, OT AUSTRALIA National, Fitzroy, Victoria \.
- OT Australia 1999, *Australian Competency Standards for Occupational Therapists in Mental Health*, OT Australia, Fitzroy, Victoria.
- OT Australia 2010, *Australian minimum competency standards for new graduate occupational therapists*, OTAustralia.
- Padgett, D 2008, *Qualitative methods in social work research*, 2nd edn, Sage, Thousand Oaks, CA.
- Padgett, D 2009, 'Qualitative and mixed methods in social work knowledge development', *Social Work*, vol. 54, no. 2, pp. 101-105.
- Parker, H 2001, 'The role of occupational therapist in community mental health teams: Generic or specialist?', *British Journal of Occupational Therapy*, vol. 64, no. 12, pp. 609-611.
- Paterson, M, Higgs, J & Wilcox, S 2005, 'The artistry of judgement: A model for occupational therapy practice', *British Journal of Occupational Therapy*, vol. 68, no. 9, pp. 409-417.
- Paul, S 1996, 'Mental health: An endangered occupational therapy speciality ', *The Amercian Journal of Occupational Therapy*, vol. 50, no. 1, pp. 65-68.
- Payne, M 1982, *Working in teams*, Macmillan, Basingstoke.
- Perron, A, Fluet, C & Holmes, D 2005, 'Agents of care and agents of the state: Bio-power and nursing practice', *Journal of Advanced Nursing*, vol. 50, no. 5, pp. 536-44.
- Pettican, A & Bryant, W 2007, 'Sustaining a focus on occupation in community mental health practice', *British Journal of Occupational Therapy*, vol. 70, no. 4, pp. 140-146.
- Pollard, N, Sakellariou, D & Lawson-Porter, A 2010, 'Will occupational science facilitate or divide the practice of occupational therapy?', *International Journal of Therapy and Rehabilitation*, vol. 17, no. 1, pp. 40-47.

Appendices

- Polyani, M 1966, *The tacit dimension*, Routledge & Kegan Paul Ltd, London.
- Quick, L, Forsyth, K & Melton, J 2007, 'From graduate to reflective practice scholar ', *British Journal of Occupational Therapy*, vol. 70, no. 11, pp. 471-474.
- Reed, KL 1984, 'Understanding theory: The first step in learning about research', *The American Journal of Occupational Therapy*, vol. 38, no. 10, pp. 677-682.
- Reed, KL & Sanderson, SR 1980, *Concepts of occupational therapy*, Williams & Wilkins, Baltimore.
- Reeves, S & Summerfield Mann, L 2004, 'Overcoming problems with generic working occupational therapists based in community mental health settings', *British Journal of Occupational Therapy*, vol. 67, no. 6, pp. 265-268.
- Reibero, KLG 2005, 'Reflections on the recovery paradigm: Should occupational therapists be interested?', *Canadian Journal of Occupational Therapy*, vol. 72, no. 2, pp. 96-102. Available from: rzh.
- Reilly, M 1962, 'The Eleanor Clarke Slagle: occupational therapy can be one of the great ideas of 20th century medicine', *American Journal of Occupational Therapy*, vol. 16, no. 1, pp. 1-9.
- Reissman, CK 2008, *Narrative methods for the human sciences*, Sage Publications, Los Angeles, CA.
- Renwick, R, Friedland, J, Sernas, V & Raybould, K 1990, 'Crisis in psychosocial occupational therapy: A closer look', *Canadian Journal of Occupational Therapy*, vol. 57, no. 5, pp. 279-84.
- Richards, L 2005, *Handling qualitative data: A practical guide*, Sage, London.
- Rickwood, D 2004, 'Recovery in Australia: Slowly but surely ', *Australian e-Journal for the Advancement of Mental Health (AeJAMH)*, vol. 3, no. 1.
- Ritchie, J & Lewis, J (eds) 2003, *Qualitative research practice: A guide for social science students and researchers*, Sage Publications Ltd, London.
- Robertson, LJ & Griffiths, S 2009, 'Graduates' reflections on their preparation for practice', *The British Journal of Occupational Therapy*, vol. 72, no. 3, pp. 125-132.
- Robinson, AM & Cynkin, S 1990, *Occupational therapy and activities health: Toward health through activities*, 2nd edn, Little Brown and Company, Philadelphia.

Appendices

- Rodger, S, Thomas, Y, Holley, S, Springfield, E, Edwards, A, Broadbridge, J, Greber, C, McBryde, C, Banks, R & Hawkins, R 2009, 'Increasing the occupational therapy mental health workforce through innovative practice education: A pilot project', *Australian Occupational Therapy Journal* vol. 56, no. 6, pp. 409-417.
- Rodgers, JC 1983, 'Clinical reasoning: The ethics, science and art [Eleanor Clarke Slagle Lecture 1983]', *American Journal of Occupational Therapy*, vol. 37, pp. 601-616.
- Roemer, M 1995, *Telling stories: Post modernism and the invalidation of traditional narrative*, Rowman & Littlefield Publishers, Inc., Lanham, Maryland.
- Rosen, A 2006a, 'The Australian experience of deinstitutionalization: interaction of Australian culture with the development and reform of its mental health services', *Acta Psychiatrica Scandinavica. Supplementum*, vol. 113, pp. 81-89. Available from: a9h.
- Rosen, A 2006b, 'The community psychiatrist of the future', *Current Opinion in Psychiatry*, vol. 19, no. 4, pp. 380-388.
- Rosen, A & Callaly, T 2005, 'Interdisciplinary teamwork and leadership: Issues for psychiatrists', *Australasian Psychiatry*, vol. 13, no. 3, pp. 234-40.
- Rudman, DL & Dennhardt, S 2008, 'Shaping knowledge regarding occupation: Examining the cultural underpinnings of the evolving concept of occupational identity', *Australian Occupational Therapy Journal*, vol. 55, no. 3, pp. 153-162.
- Ryan, S 2010, 'Reasoning using occupational analysis', in *Occupational analysis in practice*, eds L Mackenzie & G O'Toole, Wiley-Blackwell, Sydney.
- Ryle, G 1949, *Theory of the mind*, Kessinger Publishing, London.
- Saldana, J 2009, *The coding manual for qualitative researchers*, SAGE Publications Ltd, Thousand Oaks, California, US.
- Scanlon, J, Still, M, Stewart, K & Croaker, J 2010, 'Recruitment and retention issues for occupational therapists in mental health: Balancing the pull and the push', *Australian Occupational Therapy Journal* vol. 57, no. 2, pp. 102-110.
- Schell, BB & Schell, JW 2008, *Clinical and professional reasoning in occupational therapy*, Wolters Kluwer Lippincott Williams & Wilkins, Philadelphia.

Appendices

- Schkade, J & McClung, M 2001, *Occupational adaptation in practice: Concepts and cases*, Slack Incorporated, Thorofare, NJ.
- Schkade, J & Schultz, S 1992, 'Occupational adaptation: Toward a holistic approach to contemporary practice, Part 1', *American Journal of Occupational Therapy*, vol. 46, pp. 829-837.
- Schön, D 1983, *The reflective practitioner*, Basic, New York.
- Schön, D 1987, *Educating the reflective practitioner: Toward a new design for teaching and learning in the professions*, Jossey-Bass., San Francisco.
- Schore, J & Schore, A 2008, 'Modern attachment theory: The central role of affect regulation in development and treatment', *Clinical Social Work Journal*, vol. 36, pp. 9-20.
- Schwandt, TA 1994, 'Constructivist, interpretivist approaches to human inquiry', in *Handbook of qualitative research*, eds N Denzin & Y Lincoln, Sage Publications, Thousand Oaks, California, pp. 118-137.
- Schweiger, WK & O'Brien, M 2005, 'Special needs adoption: An ecological systems approach', *Family Relations*, vol. 54, pp. 512-522.
- Sedgewick, A, Cockburn, L & Trentham, B 2007, 'Exploring the mental health roots of occupational therapy in Canada: A historical review of primary texts 1925-1950', *Canadian Journal of Occupational Therapy*, vol. 74, no. 5, pp. 407-417.
- Sefton, AJ 2001, 'Integrating knowledge and practice in medicine', in *Practice knowledge and expertise in the health professions*, eds J Higgs & A Titchen, Butterworth and Heinemann, Oxford, pp. 29-34.
- Sheldon, B 2000, 'Cognitive behavioural methods in social care: A look at the evidence (eds), *Social Work Models, Methods and Theories*', in, eds P Stepney & D Ford, Russell House Publishers, Lyme Regis
- Silverman, D 2000, *Doing qualitative research: A practical handbook*, Sage Publications Ltd, London.
- Skjørshammer, M 2002, 'Understanding conflicts between health professionals: A narrative approach', *Qualitative Health Research*, vol. 12, no. 7, pp. 915-931.
- Smeby, J-C 2007, 'Connecting to professional knowledge', *Studies in Higher Education*, vol. 32, no. 2, pp. 207-224.
- Smith, E & Mackenzie, L 2011, 'How occupational therapists are perceived within inpatient mental health settings: The perceptions of seven Australian nurses', *Australian Occupational Therapy Journal*, vol. 58, no. 4, pp. 251-260.

Appendices

- Stark, S, Cooke, P & Stronach, I 2000, 'Minding the gap: Some theory-practice disjunctions in nursing education research', *Nurse Education Today*, vol. 20, no. 2, pp. 155-163.
- Stark, S, Skidmore, D, Warne, T & Stronach, I 2002, 'Mental health nursing. A survey of 'teamwork' in mental health: Is it achievable in practice?', *British Journal of Nursing*, vol. 11, no. 3, pp. 178-86.
- Stark, S, Stronach, I & Warne, T 2002, 'Teamwork in mental health: Rhetoric and reality', *Journal of Psychiatry and Mental Health Nursing*, vol. 9, no. 4, pp. 411-418.
- Tobin, G & Begley, C 2004, 'Methodological rigour within a qualitative framework', *Journal of Advanced Nursing*, pp. 388-396.
- Törnebohm, H 1991, 'What is worth knowing in occupational therapy?', *The American Journal of Occupational Therapy*, vol. 45, no. 5, pp. 451-454.
- Townsend, E & Wilcock, A 2004, 'Occupational justice and client-centred practice: A dialogue in progress', *Canadian Journal of Occupational Therapy*, vol. 71, no. 2, pp. 75-87.
- Townsend, EA & Polatajko, H 2007, *Enabling occupation II: Advancing an occupation vision for health, well-being, and justice through occupation* CAOT Publications ACE, Ottawa, ON.
- Trevithick, P 2008a, 'Revisiting the knowledge base of social work: A framework for practice', *British Journal of Social Work*, vol. 38, no. 6, pp. 1212-1237.
- Trevithick, P 2008b, 'Revisiting the Knowledge Base of Social Work: A Framework for Practice.', *British Journal of Social Work*, vol. 38, no. 6, pp. 1212-1237.
- Trevithick, P 2012, 'Practice perspectives. In Gray, M., Midgley, J., & Webb, S.A. (eds). Handbook of Social Work. London: Sage.', in *Handbook of Social Work.*, eds M Gray, J Midgley & SA Webb, Sage, London.
- Turpin, M & Iwama, MK 2011, *Using occupational therapy models in practice: A field guide*, Churchill Livingstone Elsevier, Edinburgh.
- Valaitis, RK, Akhtar-Danesh, N, Brooks, F, Binks, S & Semogas, D 2011, 'Online communities of practice as a communication resource for community health nurses working with homeless persons', *Journal of Advanced Nursing*, vol. 67, no. 6, pp. 1273-1284. Available from: rzh.
- Van Deusen, J 1981, 'Occupational therapy theory development: Knowledge and values held by recent graduates', *Occupational Therapy Journal of Research*, vol. 1, no. 1, pp. 70-93.

Appendices

- Van Deusen, J 1985, 'Relationship of occupational therapists' education and experience to perceived value of theory development', *Occupational Therapy Journal of Research*, vol. 5, no. 4, pp. 223-231.
- Van Deusen, J 1986, 'Occupational therapy theory: Values held by undergraduate students ', *Occupational Therapy Journal of Research*, vol. 6, no. 2, pp. 115-122.
- Wenger, E, McDermott, RA & Snyder, W 2002, *Cultivating communities of practice a guide to managing knowledge*, Harvard Business School Press, Boston, MA.
- Wengraf, T 2001, *Qualitative research interviewing: Biographical narrative and semi-structured methods*, Sage Publications, London.
- Whitcher, K & Tse, S 2004, 'Counselling Skills in Occupational Therapy: a Grounded Theory Approach to Explain their Use within Mental Health in New Zealand', *The British Journal of Occupational Therapy*, vol. 67, pp. 361-368.
- Whiteford, GE, Townsend, EA & Hocking, C 2000, 'Reflections on a renaissance of occupation', *Canadian Journal of Occupational Therapy*, vol. 67, no. 1, pp. 61-69.
- Whiteford, GE & Wilcock, AA 2001, 'Centralizing occupation in occupational therapy curricula: Imperative of the new millennium', *Occupational Therapy International*, vol. 8, no. 2, pp. 81-85.
- Whittemore, R, Chase, SK & Mandle, CL 2001, 'Validity in qualitative research', *Qualitative Health Research*, vol. 11, no. 4, pp. 522-537.
- Wicks, A & Whiteford, G 2003, 'Value of life stories in occupation-based research', *Australian Occupational Therapy Journal* vol. 50, no. 2, pp. 86-91.
- Wikeby, M, Lundgren Pierre, B & Archenholtz, B 2006, 'Occupational therapists' reflection on practice within psychiatric care: A Delphi study', *Scandinavian Journal of Occupational Therapy*, vol. 13, no. 3, pp. 151-159. Available from: a9h.
- Wilcock, A 1998, *An occupational perspective of health*, Slack Incorporated, Thorofare, NJ.
- Wilding, C 2011, 'Raising awareness of hegemony in occupational therapy: The value of action research for improving practice', *Australian Occupational Therapy Journal*, vol. 58, no. 4, pp. 293-299.
- Wilding, C, Marais-Strydom, E & Teo, N 2003, 'MentorLink: Empowering occupational therapists through mentoring', *Australian Occupational Therapy Journal* vol. 50, no. 4, pp. 259-261.

Appendices

- Wilding, C & Whiteford, GE 2007, 'Occupation and occupational therapy: Knowledge paradigms and everyday practice ', *Australian Occupational Therapy Journal* vol. 54, no. 3, pp. 185–193.
- Wilding, C & Whiteford, GE 2008, 'Language, identity and representation: Occupation and occupational therapy in acute settings', *Australian Occupational Therapy Journal* vol. 55, no. 3, pp. 180-187.
- Wood, W, Nielson, C, Humphry, R, Coppola, S, Baranek, G & Rourke, J 2000, 'A curricular renaissance: Graduate education centred on occupation', *American Journal of Occupational Therapy*, vol. 54, no. 6, pp. 586-597.
- World Federation of Occupational Therapists 2002, *Minimum standards for the education of occupational therapists*, The Council of the World Federation of Occupational Therapists, Perth.
- World Federation of Occupational Therapists 2012, *Definitions of occupational therapy from member organisations*, World Federation of Occupational Therapists.
- Xyrichis, A & Lowton, K 2008, 'What fosters or prevents interprofessional teamworking in primary and community care? A literature review', *International Journal of Nursing Studies*, vol. 45, no. 1, pp. 140-53.
- Xyrichis, A & Ream, E 2008, 'Teamwork: A concept analysis', *Journal of Advanced Nursing*, vol. 61, no. 2, pp. 232-41.
- Yerxa, E & Johnson, JA 1989, *Occupational Science: The foundation for new models of practice.*, Hawroth Press, New York.
- Young, M & Cenin, E 1992, *Theories and principles of occupational therapy*, Churchill Livingstone, Edinburgh.
- Zemke, R & Clark, F 1996, *Occupational science: The evolving discipline*, FA Davis, Philadelphia.

APPENDICES

I.	Ethics Approval Letters- Copies of ethics Extras: Ethics clearance statement
II.	Information statement
III.	Consent form
IV.	Interview Schedule/Aide memoir
V.	Visual mapping of Diana's professional history

Appendices

Appendix I-Human Research Ethics Committees' Approvals

Insert a copy of the html of Hunter
New England Health one page

Insert

21 July 2008

Professor S Ryan
Occupational Therapy
School of Health Sciences
University of Newcastle

Dear Professor Ryan,

**RE: Practice knowledge valued by occupational therapists in mental health settings
(08/06/18/5.07)**

**HNEHREC Reference No: 08/06/18/5.07
NSW HREC Reference No: 08/HNE/164**

Thank you for submitting the above protocol which was first considered by the Hunter New England Human Research Ethics Committee at its meeting held on **18 June 2008**. This Human Research Ethics Committee is constituted and operates in accordance with the National Health and Medical Research Council's *National Statement on Ethical Conduct in Human Research (2007)* (National Statement) and the *CPMP/ICH Note for Guidance on Good Clinical Practice*.

I am pleased to advise that following receipt of the requested clarifications and revised information sheet and interview schedule by the Professional Officer, the Hunter New England Human Research Ethics Committee has granted ethical approval of the above project.

The following documentation has been reviewed and approved by the Hunter New England Human Research Ethics Committee:

- The Participant Information Statement (version 2 dated 10 July 2008);
- The Participant Consent Form; and
- The Interview Schedule

For the protocol **Practice knowledge valued by occupational therapists in mental health settings**

Approval from the Hunter New England Human Research Ethics Committee for the above protocol is given for a maximum of **5 years** from the date of this letter, after which a renewal application will be required if the protocol has not been completed.

The *National Statement on Ethical Conduct in Human Research (2007)*, which the Committee is obliged to adhere to, include the requirement that the committee monitors the research protocols it has approved. In order for the Committee to fulfil this function, it requires:

- a report of the progress of the above protocol be submitted at 12 monthly intervals. Your review date is **July 2009**. A proforma for the annual report will be sent two weeks prior to the due date.

Hunter New England Human Research Ethics Committee

(Locked Bag No 1)
(New Lambton NSW 2305)
Telephone (02) 49214 950 Facsimile (02) 49214 818
Email: hnehrec@hnehealth.nsw.gov.au
Nicole.gerrand@hnehealth.nsw.gov.au
Michelle.lane@hnehealth.nsw.gov.au
http://www.hnehealth.nsw.gov.au/Human_Research_Ethics

Appendices

Appendix II-Information Statement

4 pages

Appendix II-Information Statement

//

Professor Susan Ryan
School of Health Sciences
Faculty of Health
University of Newcastle
University Drive
CALLAGHAN
NSW 2308
Phone: +61 (0) 2 492 16643
Fax: +61 (0) 2 492 17902

HYPERLINK "mailto:Susan.Ryan@newcastle.edu.au" Susan.Ryan@newcastle.edu.au

Participant Information Statement for the Research Project:
Practice knowledge valued by occupational therapists in mental health settings
HNEHREC Reference NO: 08/06/18/15.07
NSW HREC Reference No: 08/HNE/164

You are invited to participate in the research project identified above which is being conducted by Professor Susan Ryan and Samantha Ashby from the School of Health Sciences at the University of Newcastle. The research is part of Samantha Ashby's PhD in Occupational Therapy at the University of Newcastle, supervised by Professor Susan Ryan from the School of Health Sciences.

Why is the research being done?

The current literature in occupational therapy often discusses a gap between theory and practice however, few studies have asked clinically based occupational therapists about the knowledge that they value in practice, and how this knowledge is utilised in mental health settings. The purpose of the research is to explore the knowledge valued by experienced occupational therapists who work in mental health settings within the Hunter New England Health Area.

Every day in practice, occupational therapists need to be able to justify their knowledge sources to other disciplines and to service users. This study aims to capture your ideas about your practice knowledge through the sharing of practice stories and experiences. The study is interested in all types of practice knowledge not just that derived from models of practice.

The information from the study will improve our understanding about the knowledge that occupational therapists value and use in mental health practice settings and will inform undergraduate and post-graduate program design and assist in preparing continuing professional development courses.

Who can participate in the research?

You have been nominated by the Professional Lead in Occupational Therapy as an experienced occupational therapist in mental health practice in the Hunter New England Area and are invited to participate in this research. Only the first eight experienced occupational therapists who volunteer will be needed to participate at this time.

What choice do you have?

Participation in this research is entirely your choice. Only those people who give their informed consent will be included in the project. Whether or not you decide to participate, your decision will not disadvantage you.

Appendix II-Information Statement

If you decide to participate, you may withdraw from the study at any time without giving a reason and you also have the option of withdrawing your data.

What would you be asked to do?

If you agree to participate, you will be asked to take part in two individual face-to-face interviews and one focus group. If you would like to participate, you need to contact Sam Ashby or Professor Ryan within one month of receiving this information statement.

The interviews will be at least one and a half hours in length. They will be carried out at any location chosen by you which has a quiet room, either at your workplace or at the University of Newcastle. Each interview will be audio taped and transcribed verbatim. At any time during the interviews, you can ask for the tape to be stopped and sections of it edited or erased.

As a participant, you will be asked to share information about your practice experiences and the type of knowledge that you value in your practice. During the first interview you will be asked to describe the knowledge you value in practice. The second interview will take place four-six weeks after the first and will be semi-structured with the researcher asking for your reflections about the previous interview and for more information that relates to your practice knowledge.

Following the completion of the interview stage, all participants will be invited to attend a focus group to discuss their collective ideas and thoughts with other participating therapists about what knowledge is valued and used in practice. The focus group will take place at The University of Newcastle and will last for approximately two hours. The focus group will be recorded and transcribed and the researcher will also take notes.

You will be posted a copy of your narrative interview, semi-structured interview and focus group transcripts and you will be able to edit or erase parts of your contribution. You will also be asked to "member check" your transcripts to ensure the trustworthiness of the data and to verify their accuracy. This process will enable you to edit, to add, or to clarify any points that you wish.

You will be given a summary of the findings from the research at the conclusion of the study and will be informed when it is published, disseminated at conferences or used for educational purposes.

What are the risks and benefits of participating?

There will be no direct benefits to you as an individual. However, you will be contributing to furthering the understanding of the knowledge used by clinicians in practice in mental health. There are no foreseeable risks other than the time you spend to participate in this research.

How will your privacy be protected?

Any information collected by the researchers will be stored securely and only accessed by the researchers, unless you specifically consent otherwise. All information you provide is considered confidential. You will be asked to choose a pseudonym and all information that could identify you or your work place will be removed by the researcher from the transcripts. This ensures that your name will not appear on any report or article resulting from the research. As previously stated, you will also be able to review the transcripts to edit or erase any parts of your contribution, which you think could compromise your privacy.

Data collected during this study will be retained for at least five years in Professor Ryan's locked office.

How will the information collected be used?

Appendix II-Information Statement

The information from this study will be used in a thesis written as part of the PhD Research Higher Degree program requirements at the University of Newcastle. The aim is for the research findings to be published in relevant journals and disseminated at conferences. Individual participants will not be identified in any reports, articles or presentations arising from the project and no identifying features will be included in any publications.

Appendix II-Information Statement

What do you need to do to participate?

Please read this Information Statement and be sure you understand its contents before you consent to participate. You have one month to consider your participation. If there is anything you do not understand, or you have questions, contact the researcher, Samantha Ashby, on 0413941670 or via e-mail: [HYPERLINK "mailto:Samantha.Ashby@newcastle.edu.au"](mailto:Samantha.Ashby@newcastle.edu.au)
Samantha.Ashby@newcastle.edu.au

If you would like to participate, please complete the attached Consent Form and please return it in the stamped addressed envelope enclosed to:

Professor Susan Ryan
School of Health Sciences
Faculty of Health
University of Newcastle
University Drive
CALLAGHAN
NSW 2308

Sam will then contact you to arrange a time convenient to you for the interview.

Further information

If you would like further information please contact Professor Susan Ryan on (02) 4921 6643 or [HYPERLINK "mailto:susan.ryan@newcastle.edu.au"](mailto:susan.ryan@newcastle.edu.au) susan.ryan@newcastle.edu.au or Samantha Ashby on 0413941670 or [HYPERLINK "mailto:Samantha.Ashby@newcastle.edu.au"](mailto:Samantha.Ashby@newcastle.edu.au)
Samantha.Ashby@newcastle.edu.au

Thank you for considering this invitation.

Professor Susan Ryan
Research Supervisor
Phone: (02) 4921 6643

E-mail: [HYPERLINK "mailto:Susan.Ryan@newcastle.edu.au"](mailto:Susan.Ryan@newcastle.edu.au) Susan.Ryan@newcastle.edu.au

E-mail: [HYPERLINK "mailto:Samantha.Ashby@newcastle.edu.au"](mailto:Samantha.Ashby@newcastle.edu.au)

Samantha.Ashby@newcastle.edu.au

Samantha Ashby
PhD Student

Phone: (02) 49213641/0413941670

Complaints about this research

This research has been approved by the Hunter New England Human Research Ethics Committee of Hunter New England Health, Reference: 08/06/18/5.07

Should you have concerns about your rights as a participant in this research, or you have a complaint about the manner in which the research is conducted, it may be given to the researcher, or, if an independent person is preferred, to Dr Nicole Gerrand, Professional Officer (Research Ethics and Governance), Hunter New England Human Research Ethics Committee, Hunter New England Health, Locked Bag 1, New Lambton NSW 2305, telephone (02) 49214950, email HNEHREC@hnehealth.nsw.gov.au

FACULTY OF HEALTH



Professor Susan Ryan
School of Health Sciences
Faculty of Health
University of Newcastle
University Drive
CALLAGHAN
NSW 2308
Phone: +61 (0) 2 492 16643
Fax: +61 (0) 2 492 17902
Susan.Ryan@newcastle.edu.au

Participant Consent Form for the Research Project:

Practice knowledge valued by occupational therapists in mental health settings

Professor Susan Ryan and Samantha Ashby

I agree to participate in the above research project and give my consent freely.

I understand that the project will be conducted as described in the Information Statement, a copy of which I have retained.

I understand I can withdraw from the project at any time and do not have to give any reason for withdrawing.

I consent to:

- participate in two interviews and have them recorded and transcribed.
- attend a focus group.
- review my interview transcripts and the focus group transcripts for "member checking" to ensure the trustworthiness of the data and to verify the accuracy of the transcripts
- alter my interview and focus group transcripts if I wish to do so.

I understand that my personal information will remain confidential to the researchers and that I can choose my own pseudonym.

I have had the opportunity to have questions answered to my satisfaction.

Print Name: _____

Contact details: (To arrange interview times)

E-mail address: _____

Postal Address: _____

Preferred Phone Numbers: _____ (preferred times to call) _____

Signature: _____ **Date:** _____

Appendix III-Consent Form

Appendix IV Interview Schedule

Interview Schedule

The semi-structured interview schedule will be derived from literature about the different types of knowledge used in practice (de Cossart and Fish, 2005, p.197) and deeper probing questions to clarify points from the first narrative interview.

The main themes to be considered

Propositional knowledge

Questions relate to the formal specialist theory used by occupational therapists in mental health: and how they integrate generic theory, the context, and knowledge of context, of education, of management, of organization, of profession, of society used by the occupational therapist.

Evidence-based knowledge

Knowledge of all appropriate research where relevant.

Propositional adaptation knowledge

Questions relate to how the occupational therapist may reorganise factual knowledge and skills to respond to the given case?

Procedural knowledge

Questions relate to skills know-how, processes, procedures related to: clinical, managerial, educational, research, and organizational.

Procedural improvisation knowledge

Questions relate to how they use and adapt know-how safely to the given context.

Professional knowledge and conduct

Questions relate to how they value the knowledge of the traditions and parameters of the practice of the profession and its legal framework

Experiential knowledge

Knowledge gained from undergoing experiences and reflecting on them to make sense of them and learn from them

Practice-generated knowledge

New knowledge created through undertaking, exploring, and theorizing an aspect of professional practice (can lead to new propositional and procedural knowledge).

Example of question: Do you use your own practice knowledge rather than utilising the models of practice which have an available evidence base?

Ethical knowledge

Knowledge of ethical and moral principles that guide all professional practice and that shape the safe improvisation of procedural knowledge and the reorganization of propositional knowledge.

Self-knowledge

Accurate knowledge of own personal characteristics, values and beliefs, plus procedural capabilities and grasp of propositional knowledge.

Intuitive knowledge

Something that we know or are moved to do but cannot (yet) give logical or evidential grounds for

Example of Question: Do you sometimes 'just know something or what to do?

Meta-cognitive knowledge (mostly tacit or implicit)

Knowledge of the structure of knowledge and higher order ways of organising knowledge

Example of Question: In practice is there one area of knowledge that you could not practice without?

Why do you think there is little information available on the knowledge that occupational therapists value in practice and how theoretical knowledge is utilised in mental health settings?

- **How knowledge is used in clinical interactions.**

Appendices

In clinical practice settings health professionals must be able to justify their knowledge sources to other disciplines and to service users.

Example of questions: How do you justify your knowledge to team members/managers etc.

- **Influences on the knowledge they value.**

What are your thoughts about whether the use of theory to underpin practice ensures the continuance of clinical competence and provides a rationale for occupational therapy interventions?

Do you think that your personal knowledge and beliefs have an impact on the knowledge that you value and utilise in practice?

Why do you consider one model more attractive than another?

Does the setting you work in influence your choice of models or knowledge you use in practice

- **Where they obtain their practice knowledge.**

What are the multiple sources they gain their knowledge from? Do they consider one to be more valued than another?