Chronic obstructive pulmonary disease (COPD) is a chronic and slowly progressive disorder characterized by airway obstruction (Standards of Care Committee of the British Thoracic Society, 1997). Various factors are associated with the onset of the disease including cigarette smoking or working in an environment with poor air quality (Burrow, Knudson, Cline, & Lebowitz, 1979; Doll, Peto, Wheatley, Gray, & Sutherland, 1994). People with the condition often have symptoms of cough, overproduction of sputum, and dyspnea (i.e., a shortness of breath) with increasing frequency of acute episodes such as respiratory infection. Due to the chronic and progressive nature of the disease, most of the lung function impairments are permanent although some might be reversible with bronchodilator therapy (Standards of Care Committee of the British Thoracic Society, 1997). Patients with mild COPD may have minimal symptoms, such as occasional morning cough, recurrent respiratory infection, or shortness of breath on strenuous exertion. As the disease progresses, coughing and sputum production may increase, leading to breathlessness or wheezing on moderate physical exertion. At the late stage, patients often experience frequent acute episodes with progressive chronic breathlessness or respiratory-related complications.

As a result of the symptoms mentioned above, persons with COPD, who are often elderly, face increasingly severe respiratory symptoms across time. These symptoms, in turn, increasingly limit people's participation in various activities of daily living (ADL). At the early stage of the disease, people might have difficulties in stair climbing and doing outdoor activities. As the disease progresses, people may have problems doing activities requiring minimal physical exertion, such as dressing, feeding, and grooming. They might experience significant breathlessness...
even at rest. As a result, over time people with the disease experience a decline in their physical ability and may feel they have less and less personal control over activities that once seemed to be basic and easy. They may then gradually lose confidence in their abilities to perform ADL. In addition, they may often experience a sense of fear related to frequent exacerbation and respiratory infection. This fear may further hinder them from participating in various daily activities (Matthews, 2001; Toshima, Kaplan, & Ries, 1992).

Apart from pharmaceutical interventions, various multidisciplinary pulmonary rehabilitation programs with physical therapy and occupational therapy have been designed to control symptoms, maintain patients’ physical tolerance, and teach them to acquire coping skills, breathing skills, and relaxation techniques (Lacasse, Guyatt, & Goldstein, 1997). While physical therapy seeks to enhance or maintain the cardiopulmonary functions of the participants, occupational therapists often conduct educational groups to teach participants with COPD to acquire pursed-lip breathing, coordinated breathing skills, and energy conservation techniques. Furthermore, patients are also often taught relaxation methods (e.g., imagery relaxation) (Harding, 1996; Tusek & Cwynar, 2000), to help them manage situations in which they feel anxiety and stress. The overall goal of the occupational therapy intervention is to facilitate participants’ continual engagement or reengagement in various ADL and to carry out life roles to the extent that their ability allows.

The effectiveness of occupational therapy interventions is often measured by assessments of the severity of the dyspneic condition and fatigue. Self-rated scales on dyspnea and exertion are commonly used in clinical settings. The chronic respiratory disease questionnaire (CRDQ) is a standardized tool used to measure the severity of COPD in terms of four domains, namely dyspnea, fatigue, coping, and mastery (Guyatt, Berman, Townsend, Pugsley, & Chambers, 1987). These quantitative methods, however, mainly focus on the symptoms of the disease itself rather than the disease experience. Further, a systematic review of the literature (Lacasse et al., 1997) concluded that the effects of education groups on patients in comprehensive rehabilitation programs were limited when evaluated by conventional quantitative positivistic research designs. Studies cited by Lacasse and colleagues focused on improvements in knowledge about the disease, attitudes regarding the disease, locus of control, or mental health status as program outcomes (Ashikaga, Vacek, & Lewis, 1980; Howland, Nelson, & Barlow, 1986; Renfoe, 1988).

One of the main goals of occupational therapy is to help participants with COPD to reengage in their daily occupations (Lacasse et al., 1997). Nevertheless, how people with COPD experience and perceive the illness and how much the disease affects their engagement in meaningful activities on a daily basis are not reflected in conventional quantitative assessments. Furthermore, their experiences in the occupational therapy intervention have seldom been explored in the literature.

Occupation has been defined as “people’s goal-directed use of time, energy, interest, and attention in work, leisure, family, cultural, self-care, and rest activities” (Wilcock, 1991, p. 297). In occupational therapy, we assume that engaging in occupation is essential to the significance and meaning of life and that occupation has the capacity to influence a person’s well-being. Yerxa (1987) argued that, in order to investigate the connection between humans and their occupations, a qualitative approach might best be adopted. Among various possible qualitative methods, interviews have the potential to allow people to “tell their stories” about their disease experience in an unobtrusive way. These stories are sometimes referred to as “conversations” (Kvale, 1996, pp. 19–37) between narrator and researcher. Thematic analysis can be applied to these “conversations” to identify “themes and patterns of living and behavior” (Aronson, 1994, ¶ 3). Thus “conversations” become a key to understanding participants’ disease experiences.

The aims of the current study were (1) to explore from the participants’ perspective the experience of COPD as related to engagement in daily occupations, and (2) to examine from the participants’ perspective their experiences of an occupational therapy intervention designed for people with COPD as related to their engagement in meaningful occupations.

Research Methodology

Basic Design

A qualitative approach was used in which interviews were conducted with participants to allow them to share their experiences of COPD as mentioned earlier. Kvale (1996) has characterized such interviews as conversations between the participants and the interviewers. This is similar to phenomenological approaches (Gray, 1997; Marshall & Rossman, 1994), which assume that individuals construct their own realities through their personal experiences and their perceptions of those experiences. The focus is on understanding what it means to be human beings who create meanings and take a stand within the historical, social, and cultural context of their lives (Newman, 1986). In this study, the understandings were generated through collaboration between the researcher...
and participants with COPD using interviews in order to understand the subjective experiences and points of view of people with COPD.

Participants and the Setting

Four participants were recruited for the study from the pulmonary rehabilitation program in one of the rehabilitation hospitals in the northern region of Hong Kong during the period from January to March 2002. Three completed the entire interview process since one participant was discharged early. The inclusion criteria for the participants were: (1) COPD as the primary diagnosis, (2) in a pulmonary rehabilitation program for the first time, (3) living in community settings, and (4) showed they were capable and willing to share and express their personal experiences and feelings. Each participant admitted to the pulmonary rehabilitation program was required to stay in the rehabilitation hospital for 4 weeks in order to receive 4-week multidisciplinary interventions. Table 1 provides the demographics of 3 participants. All names are pseudonyms in Chinese. Potential participants were invited to take part in the study during the first week of the pulmonary rehabilitation program.

In addition to medical consultation from medical officers and health education from nursing personnel, participants in the pulmonary rehabilitation program were required to take part in cardiopulmonary training in the physical therapy department. They also received occupational therapy interventions including group education sessions on coordinated breathing technique and energy conservation. Individual sessions in occupational therapy were also arranged in order to reinforce individual skills in various daily living activities and to meet personal needs. As an adjunct to the educational classes, participants were also requested to participate in relaxation sessions in which an imagery relaxation technique was used (Harding, 1996; Tusek & Cwynar, 2000). Activity groups, such as leisure groups, craft groups, or tea groups were also arranged for all participants in order to provide them with opportunities to express or explore their leisure interests.

Data Collection and Analysis

Two semistructured interviews with each of the three research participants were conducted—one in the first week and one in the last week of the 4-week pulmonary rehabilitation program. The Occupational Performance History Inventory (Kielhofner, Henry, & Waleas, 1989) was adapted to provide a comprehensive framework for semistructured interviews to explore each participant’s roles, and social and environmental interactions. The Occupational Performance History Inventory was chosen because it was based on the Model of Human Occupation (Kielhofner, 2002); the model helped the researcher to gather information about each client’s past and present occupational performance, habituation, and volition subsystems as well as the environment as influences on occupational behavior.

Each interview lasted for approximately an hour. All interviews were conducted by the researcher in the rehabilitation hospital where the pulmonary rehabilitation program was located. In order to avoid any disturbances, each interview was conducted in a room separate from other activities. The semistructured interview format allowed for natural and spontaneous conversations and interactions between the researcher and the participant. This format also allowed the participants to express their experiences of both the disease and the occupational therapy intervention in their own words.

The first and second interviews had different themes. The purpose of the first interview during week 1 was to capture understandings of the participants’ previous life events, and the impact COPD had on their occupational engagement. In the second interview, the participants were asked about their present experiences of the occupational therapy intervention, their perceptions of those interventions, and how the occupational therapy interventions influenced them to perceive their chronic disease. Future life planning for their life after they had completed the pulmonary rehabilitation program was also discussed in the second interview.

All the interviews were conducted by the researcher in Cantonese. The interviewer took notes in Cantonese during each of the interviews. In order to preserve the information as much as possible for further thematic analysis, a summary report was then written in English along with quotations in Cantonese on the same day as the interview.

With an open attitude, the researcher repeatedly read all the summary reports as a whole, and sentences and words that conveyed important information were highlighted in each report. Those quotations and key words from all interviews were grouped together and compared to generate common themes to describe how COPD affected the participants’ engagement in daily activities and how the occupational therapy interventions influenced their engagement in occupation (Aronson, 1994; Kvale, 1996).

Table 1. Demographic Characteristics of the Participants

<table>
<thead>
<tr>
<th>Participant</th>
<th>Sex/Age</th>
<th>Duration</th>
<th>Oxygen Supplement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ah Fai</td>
<td>Male/69</td>
<td>10 years</td>
<td>No (Weaned off)</td>
</tr>
<tr>
<td>Bong Kwok</td>
<td>Male/73</td>
<td>4 years</td>
<td>Yes</td>
</tr>
<tr>
<td>Chi Keung</td>
<td>Male/63</td>
<td>5 years</td>
<td>No</td>
</tr>
</tbody>
</table>
Results

Five key themes relating to the experience of COPD and participants’ engagement in occupation were identified: (1) uncertainty during the course of the disease, (2) external attribution, (3) activity restriction and isolation, (4) anxiety and depression, and (5) passive fortitude.

Uncertainty During the Course of the Disease

During the first interviews, participants tended to describe their initial experiences with the disease. When they first noticed various signs and symptoms of COPD, such as shortness of breath or overproduction of sputum, they described feeling uncertain and not knowing how to react to the situation. Bong Kwok said, “I thought that was just a flu,” and “I didn’t realize how serious my disease was at the beginning until my legs got swollen.” Chi Keung also said, “I didn’t know what it [the disease] was at first. I ignored it and thought it will go away. But the worsening condition told me that my assumption was wrong.” Furthermore, participants also felt uncertain when they had difficulties engaging in ordinary activities that required only minimal physical demands. This uncertainty was reflected by what Ah Fai said, “On a very hot day in July or August, I felt the shortness of breath all of a sudden while I was having a walk outside. I couldn’t walk back home even though I was just a few steps away from my place. I ended up squatting down. I was so afraid that I would never make it home. That was the first time this disease really gave me worry. I ask myself, ‘What would I do? No one’s going to help me.’” Bong Kwok also said, “I was so freaked out when I first had the shortness of breath during a shower one day. It took me all the energy to just take a break. I thought I was going to pass out! I asked myself, ‘What am I gonna do? Now I can’t even enjoy having a walk outside without having shortness of breath.’”

External Attribution

After the disease worsened, the participants reflected that they started to come up with explanations about their pulmonary conditions. In other words, they seemed to search for the potential causes of their conditions. One of the main factors that they tended to suspect at the beginning was the external or environmental influence. The participants perceived the fluctuating and unpredictable weather, especially rainy days and sudden cold and hot weather, as “exacerbating factors” for their disease condition. Ah Fai said, “It kills me when the weather gets cold or gets hot. It must be the changing that made my lungs worse.” Bong Kwok also claimed, “It’s really a hard time when it is a rainy day or a cold one.” Since air pollution was common in Hong Kong, the quality of the air also caused them to experience discomfort. Chi Keung mentioned, “You know, the downtown areas of Hong Kong was very bad every now and then. It must be very bad for my lungs. That was why I moved to the suburbs with my family, to avoid the bad-quality air.” Ah Fai also made similar points, “I just don’t know why Hong Kong’s air was so poor all the time. I just wish I had those gas masks those days. Perhaps that would make my lungs’ conditions better.” Apart from factors pertaining to the weather, the participants also made connections between their respiratory conditions and other external factors. Chi Keung stated, “At the beginning, I tried to find the reasons for my declining lung condition. Is it because of my smoking when I was really younger? Or it might be because I had been exposed in a polluted area when I was working.”

Activity Restriction and Isolation

The participants described how, as the disease progressed and as they would more and more often experience shortness of breath and other related bodily discomfort, they began to alter their pattern of engaging in various physical activities. They described restricting their activity levels in order to minimize the potential situation in which their breathing could be upset. Ah Fai said, “I sometimes go to the community center to play a flute or string instrument. But the lung disease does affect my performance in playing instruments. Every now and then I would suffer from shortness of breath. I just could not coordinate my breath to blow into the flute.” On the other hand Chi Keung said, “Before I had that disease, I liked to go out to take care of my beloved plants and vegetables at the back yard, such as trimming them, or watering them. Now I have it, I couldn’t even lean down to touch them. So I usually just stay at home if I’ve got nothing to do in particular. This is because I am afraid that shortness of breath would bother me again.” Chi Keung added, “Gradually I become a quiet person and don’t know how to communicate with others since I don’t feel good about myself.” Then he said, “I am really upset about my being so isolated.”

Anxiety and Depression

Being unable to participate in various activities and feeling isolated environmentally and socially, the participants in the study described becoming gradually more and more anxious due to airway discomfort. During this time, they seemed to realize that the chronic disease would never be cured and there was nothing that they could do about it. This realization came when the declining physical condition more and more hindered them from fulfilling their life roles. Ah Fai stated, “I needed to take care of my wife and children, and I felt quite a bit of pressure. This made my
condition worse. I just felt it was harder and harder to take care of my family. I felt so down as I thought I was no good any more. That was very depressing, you know. As time went by, they would become depressed since they thought that they felt less capable of contributing to their family. The chronic physical condition often eventually led to psychological problems. Chi Keung said, “My son had a shop that needed someone to take care of. But my declining lung condition stopped me from helping my son. I just lacked confidence in myself. I failed to contribute to my family. That was very sad.”

**Passive Fortitude**

After being confronted by various respiratory symptoms due to COPD, participants in the study seemed to accept gradually the reality of the condition without, at the same time, proactively finding ways to improve their health condition. As the participants came to believe that they were incapable of doing anything to improve their declining pulmonary function and daily performance, they chose not to self-manage the respiratory disease. Rather, they decided to “live with it.” Ah Fai said, “I am not worried about any declining condition. I am used to it now…even though it has been really tough in the past. I just need to live with it. Perhaps my life is meant to be like that.” Bong Kwok dealt with the disease in a different manner. He said, “I don’t care about my condition any more. I simply see that as a flu….Now I don’t think I can do anything about it. It might be my fate to have this kind of incurable disease. Don’t we all need to die once anyway?” While Ah Fai and Chi Keung showed their external orientation toward their chronic disease, Chi Keung, on the other hand, appeared to be “stuck” in a different negative cycle of living with his respiratory condition. Chi Keung said, “I have had this lung problem for too long that I just don’t know how to deal with it any more. I have no way out…I simply give up on it. I know it’s sad, but what can I do about it, huh?”

**Occupational Therapy Intervention and Reengagement in Occupation**

As for the outcomes of occupational therapy interventions as related to engagement in occupations, four themes were identified in the interview data: (1) increased knowledge on COPD, (2) a sense of taking control of the disease and reengagement in activities, (3) alleviation of mental burden, and (4) social support from peers and therapists.

**Increased Knowledge on COPD**

Participants reported that education groups conducted by the occupational therapists equipped them with skills that were essential for their condition. Bong Kwok said, “Joining the program has helped me a great deal, and I’ve learned a lot of things. Now I know how to do the nose-sniffs-and-mouth-puffs technique, and my health is much better.” Ah Fai said, “Before I joined the program, I thought I knew the correct way to lessen the shortness of breath. But, after these few weeks, now I know how to overcome those disturbing symptoms.” Before they joined the program, participants felt they had insufficient knowledge of their pulmonary conditions and the related symptoms. As a consequence, they described experiencing a sense of helplessness since they did not know how to deal with the respiratory condition in a positive manner. After 4 weeks of the education program, they seemed to feel that they were equipped to face their disease as shown in the quotations above. The program seemed to make them feel that they could actually do something to ameliorate their disease and to make them feel more capable to engage with those physically demanding activities in which they had come to have difficulty participating.

**A Sense of Taking Control of the Disease and Reengagement in Activities**

During the course of the education program offered by occupational therapists, the participants not only gained knowledge that was helpful to them but they also had the opportunity to try the techniques that they learned. With proper breathing techniques and energy conservation techniques learned from the education program, they were able to reengage in the activities that used to be challenging to their respiratory systems. Such positive experiences seemed to encourage them to further participate in various daily activities. Ah Fai said, “Now I can take control over the disease instead of it taking over me.” Bong Kwok stated, “Before joining the program, taking a bath was a tough job. But now I find it easier to have a bath. I was glad to join this program as I got the opportunity to retry things that I haven’t tried for long time.” Being able to reengage in a variety of activities, the participants could even resume the life roles they had abandoned as the disease was progressing. This seemed to help preserve aspects of occupational identity. Chi Keung said, “After I finished the program, I will go to my son’s company to help out…that won’t be a tough job, just a shop-keeping job, but at least they will have me to look after the company.” He also said, “After I finish the program, I will go back to look after my garden again. I will do morning T’ai Chi exercises, and move around doing that sort of thing in the front yard every morning.” Ah Fai said, “With all I learned from the program, I feel more capable of doing things I like to do. I like to go to the community centre and play instruments again.”
Alleviation of Mental Burden

During the 4-week program, participants were provided with opportunities to try different ways to relax in stressful situations. The positive experiences of relaxation seemed to help participants to feel less stressed, as they learned a more proactive skill to deal with their negative feelings associated with facing their pulmonary condition over a prolonged period of time. Ah Fai said, “The relaxation sessions made me less nervous and also less tense. I also feel less ‘down’ after the program since I know the techniques to take control over my anxiety.” Chi Keung, however, said, “Those relaxation session didn’t really help me that much. But you taught me how to relax myself, and I know the way to relax after I have tried. Now I feel much relaxed all over, less tense.” This implied that, even though participants might not attribute their sense of reduced stress to the relaxation sessions in the rehabilitation program, they seemed to think that they somehow acquired relaxation skills from therapists in other ways.

Social Support From Peers and Therapists

Because most of the occupational therapy treatments in the pulmonary rehabilitation program were given to the participants in a group format, such as educational talks and relaxation sessions, participants had the chance to interact with others with similar chronic lung conditions during these sessions. Many of the members tended to be socially isolated due to their conditions, and the interactions with other people with similar conditions may have helped them to establish social networks that they lacked before they joined the pulmonary rehabilitation program. Being among people with similar conditions also perhaps helped them realize that they were not alone in coping with the disease. They could share their disease experiences and how they dealt with their chronicity.

Bong Kwok said, “Before I joined this program, I had been so isolated at my shed house. I had almost forgotten what it was like to be with a group of people. In the program, I made different friends who had similar conditions as I do. Now I know I am not alone. We can share the tricks to deal with this long-term disease.” He added, “I think we are like family. It really makes me happy. I’ll come back to visit you when I got time.” Chi Keung also had similar feelings and he said, “We all have laughs together, and that is enjoyable.” On the other hand, the therapeutic relationship between participants and their therapists also provided them with social support. Ah Fai said, “I didn’t know the therapists are so friendly and really can listen to patients like us.” Chi Keung also said, “I think I can depend on all of you [therapists]. I feel less stressed now since I know I can always turn to you to help me solving problems…even though I leave the program in the future.

Discussion

This study has illustrated how COPD influences people's perceptions of their engagement in occupation and how occupational therapy intervention is perceived to be of assistance for reengagement in occupations. Understanding from the perspectives of patients how they experienced the disease may have the potential to enable more relevant interventions to be designed.

Based on the findings of this study, a disease like COPD appears to have not only situational but also temporal effects on each participant's occupational engagement. It is not an uncommon practice for clinicians to focus on the symptoms of COPD and how they affect the performance of various daily activities at the point of assessment. Focusing on the disease experience from the patients' perspective opens up another dimension from which to consider patient needs. It should lead occupational therapy practitioners to understand the patient's experiences as well as the clinical symptoms of the disease.

This study has suggested that, when people with COPD first experienced various signs and symptoms of the disease, they experienced a period of uncertainty. They tended to think that the disease they had was merely an ordinary disease that would go away eventually. They continued to perform the activities in which they usually engaged. However, as time went by, they realized that their assumption was by no means correct and that their performance seemed to be declining. It appeared that they felt uncertainty about dealing with the new condition perhaps since they did not have sufficient knowledge to deal with the condition. If their mind–brain–body subsystem, that is one of the subsystems of the Model of Human Occupation (Kielhofner, 2002), has been repeatedly challenged by the disease, people with COPD would try to alter their daily routine by restricting their physical activities to minimize further deterioration of the lung function (Jonsdottir, 1998). As a consequence, their daily routine of participating in any activities in the community might be adversely affected. At this stage, it could be possible that their habituation subsystem was starting to be affected. The life roles the participants used to have, such as a homemaker or a member in a band, might be further limited. In the long run, they were unable to reach out and interact with others. This possibly led to psychological burdens including anxiety and depression since participants thought that they could no longer fulfill their life roles as before. Their occupational identity was put at risk.
The findings in this study further suggest that, after a prolonged period of repeated episodes of exacerbations and remissions without significant improvements, people with COPD might choose not to deal with their respiratory condition in a proactive manner. The sense of helplessness seemed to make them try to “live” with the disease in a rather passive manner. This characteristic of external orientation appeared to be consistent with previous research findings, claiming that many Chinese people are likely to think that what has happened to them is because of fate or chance (Leung, 1996).

The findings from the second interviews reflected how the participants in the pulmonary rehabilitation program experienced the occupational therapy intervention. The participants felt that the education talks in the program helped them to increase their knowledge about the management of COPD. They said they then felt more able to take control of their chronic conditions and started trying to regain control by participating in the program. The participants' experiences in the program seemed to help transform the participants' life plots from victimic to agentic. That is, they became more active and committed in their life since they regained more control over their lives. This helped the participants to create their future in a more positive direction.

The findings of this qualitative study have implications for how occupational therapists in the future may assess and provide rehabilitation interventions to patients with chronic diseases, in this case, COPD. Conventionally, practitioners may largely focus on current disease symptoms of patients with chronic diseases, followed by rather standardized interventions aimed at symptom control. Based on this study, each patient experienced the disease uniquely and each adopted unique strategies to deal with his chronic condition. The results of this study have suggested that it would be beneficial for practitioners to appreciate the temporal nature of each patient's way of managing his or her chronic disease. A paradigmatic mindset seems indicated in which therapists view their clients as experiential beings who deal with their daily problems in a dynamic, temporal manner. Initial and continual assessments should include not only the pulmonary status and functional level of clients with chronic pulmonary disease, but also their styles of dealing with varying chronic pulmonary conditions, self-management skills, and their viewpoints toward their disease. Occupational therapists can provide clients with opportunities to reengage in forms of activities, both individual and group, they treasure, thus enhancing their integrity as occupational beings and redirecting their life plots into more positive, agentic directions.

Since this study was set up to investigate one specific type of chronic disease in one rehabilitation center, the findings may not be generalized to other types of chronic diseases in different physical and cultural settings. Moreover, further studies need be conducted with female participants to investigate if there are gender differences in the way people experience chronic diseases. Another dimension in future studies might be socioeconomic well being to see if participants from different socioeconomic groups have different attitudes to chronic disease or if their material conditions influence the way they experience disease.

Conclusion

This study has explored the experience of COPD as related to the participants' engagement in occupation. Using qualitative methods to focus on the disease experience from the temporal perspective, and adapting to various illnesses or life crises (Braveman, & Helfrich, 2001; Helfrich, Kielhofner, & Mattingly, 1994; Larson, 1996; Price-Lackey & Cashman, 1996). The same temporal phenomenon also exists in the people with COPD in the current study. The study participants seemed initially to encounter uncertainty, and then attempted to seek reasons for their lung conditions from external factors. After a prolonged period of failing to deal satisfactorily with the disease they would feel anxious and perhaps depressed. Finally, they seemed to accept the disease would be with them forever. These study findings also lent support to transformational phenomena of victimic and agentic life plots (Polkinghorne, 1996). Prior to their participation in the pulmonary rehabilitation program, the participants in this study portrayed themselves with a passive or victimic life plot in which their lives were out of control due to the prolonged challenge of their chronic condition. The integrity of their occupational identity had been jeopardized. Occupational therapy interventions in the pulmonary rehabilitation program seemed to help transform the participants' life plot from victimic to agentic. That is, they became more active and committed in their life since they regained more control over their lives. This helped the participants to create their future in a more positive direction.

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Conclusion

This study has explored the experience of COPD as related to the participants' engagement in occupation. Using qualitative methods to focus on the disease experience from the
participants’ perspective, it was suggested that participants seem to isolate themselves due to deteriorating respiratory conditions, followed by deprivation of occupation engagement and social isolation. Ultimate psychological distress seemed to result. An occupational therapy intervention within the pulmonary rehabilitation program was suggested to be able to facilitate a more positive, engaged life pattern. The agentic role of such interventions needs further research, but in the present study, from the perspective of participants at least, such a role was clearly identified.

This study has also suggested that symptoms of chronic illness such as COPD manifest themselves in the lives of individuals and affect the way individuals engage with occupation on a daily basis. Understanding how individuals experience the disease is an important prerequisite for helping them to take control over it. Both research in occupational science and practice in occupational therapy could well benefit by giving greater emphasis to this perspective in the future.

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