Incorporation of Ethnographic Methods in Occupational Therapy Assessment

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Many constructs of interest to occupational therapists can only be studied through qualitative methods. Such constructs include meaning of activity or the illness experience and the context in which these occur. The purpose of this paper is to describe how ethnographic methods used in research can be generalized and applied to clinical practice. Ethnography is compared with other qualitative research approaches and a model clinical ethnographic assessment process is described.

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regular occupations are routinely enacted. Exactly how this unit of study should be defined is a crucial issue. In examining the uses of the tools of ethnography in assessing this larger unit of the individual in context, our objectives will be the following:

- to describe ethnography as a qualitative research method
- to examine application of ethnographic research methods for use in clinical ethnographic assessment in occupational therapy
- to provide examples that contrast findings from standard assessment with those one might obtain from ethnographic assessment
- to suggest a proposed ethnographic assessment process
- to describe techniques one might use to gather and interpret data
- to consider advantages and disadvantages of ethnographic assessment in occupational therapy.

**Ethnography As a Qualitative Research Method**

In its broadest sense, ethnography is the work of describing a culture. Culture is a process of behavior and communication that has been learned by persons in the context of their past experience (Krefting & Krefting, 1991). Persons who share a similar sociocultural context will have similar but not identical patterns of behavior and communication. The object of ethnography is to understand another way of life from the participants’ viewpoints through systematic observing, detailing, describing, documenting, and analyzing the daily lives of people in a culture or subculture (Leininger, 1985). Ethnography incorporates learning from people in addition to learning about them. It is an inductive method that generates research questions rather than answering predetermined ones. (For background information on the qualitative perspective, see Kielhofner, 1982a, 1982b; Krefting, 1989a; Lutterst, 1985.) Ethnographic research is based on the assumption that knowledge of all aspects of a culture is important to an understanding of that culture. These aspects are linked by the ethnographer to produce a holistic picture of the culture, be it a remote African tribe or adults with cerebral palsy.

Two types of ethnographies are used in health care research (Morse, 1989). A **traditional ethnography** is a large scale, comprehensive study of the general and particular features of a designated culture. It is undertaken to obtain a comparative understanding of the universal and relative aspects of human behavior. In traditional ethnography, the unit of analysis may be a village, in which case the researcher moves into the village and lives with the people to collect data. This type of ethnography is most often carried out by anthropologists or sociologists, not occupational therapists. An example is Schepet-Hughes’s (1982) study of mental health in Ireland in which political, economic, religious, kinship, and ecological factors were considered in relation to the experience of schizophrenia.

Although a traditional ethnography looks at the culture as a whole, occupational therapy questions are often more specific. Such questions are particularly suited for focused, more clinically oriented ethnography (Morse, 1989). A **focused ethnography** is a small scale study concentrating on a specific area of inquiry. In occupational therapy, the unit of analysis might be mothers of children receiving treatment in a home care program, or people with brain injury and their families who are affiliated with an urban support group. Focused ethnography stresses a specific problem area and those aspects of group life that affect the problem being studied.

**Types of Qualitative Research**

**Qualitative research** is based on a philosophical approach to answering research questions. There are a number of ways of carrying out qualitative research; ethnography is only one example. Others include life history, historical analysis, phenomenology, and experiential analysis. The three most common types of qualitative methodology used in health care research are phenomenology, grounded theory, and ethnography (Lipson, 1989). These qualitative traditions have grown out of a long-standing concern about how to best study and represent human life and human action as meaningful activity. These approaches aim to describe the complexity of human experience in its context and emphasize describing daily events of peoples’ lives in their own words. Although these approaches have a similar philosophical base, they differ in the way they are conducted.

The central argument behind the use of qualitative methods is that, in studying human action, one needs to do more than observe what people do or learn what people say they do; one needs to live with and participate in some way with the people one studies. Participation is necessary to begin to understand why people do what they do and what significance their actions hold for them. Participation may mean living among the people one studies and sharing in their lives. Participation also may mean interviewing people in an empathic way, in which persons are encouraged to express their experiences and beliefs in their own words, drawing on their own metaphors, stories, and personal experiences.

Some of the most interesting current work in qualitative research is phenomenological. **Phenomenological research** is concerned with modes of textual experimentation that attempt to capture and communicate the elusiveness of meaning. Ethnographies of experience, as they are sometimes called, represent attempts to move beyond descriptions of behavior and social structure to
catch more fully how a cultural world is sensed and made sense of by its members.

Thus, phenomenological research asks what is it like to have a particular experience. It is based on the assumption that human behavior goes beyond what can be observed; its significance lies in the perspectives and meanings held by the person in a particular context (Schmid, 1981). Understanding arises both from observation of behavior and from information about persons' interpretations of their own experiences. Phenomenological research is often used to sensitize readers to an experience and to promote understanding of the particular experience under study. It is done by gathering detailed descriptive information based on intense researcher or informant relationships with relatively few people. The informant's feelings, thoughts, perceptions, beliefs, and experiences are all critical units of analysis. Hasselkus and Dickie (1990) provided an example of a phenomenological perspective in their pilot study of the experience of childbirth. Although the study was not a full-scale phenomenological project, the researchers used the critical incident strategy to gather data that they analyzed from a phenomenological perspective. Full-scale phenomenological studies are more common in nursing; an example is Bergum's (1986) study of the experience of childbirth.

Grounded theory is an inductive approach to theory generation whereby complex social processes are described. It is an exploratory qualitative research approach (Glaser & Strauss, 1967) by which conceptual models and hypotheses follow from the analysis of the data rather than precede it. Data are collected with participant observation and interviews to generate categories of data for theory construction. Whereas phenomenology is a specific research strategy, grounded theory is more an approach to analysis and may be combined with other approaches such as ethnography. An example in the occupational therapy literature is Fondiller, Rosage, and Neuhaus's (1990) exploratory study of values that influence the clinical reasoning process.

Ethnography is a generalized approach to a phenomenon that focuses broadly on cultural description. It allows the examination of a particular experience, such as disability, within a cultural context. Its perspective is broader than that of phenomenological research in that it considers the political, economic, and sociocultural context of daily life of a larger number of informants. It is also often more dependent on participant observation as a data-gathering technique. This is the most common type of qualitative research strategy in the occupational therapy literature; examples include Kibele and Llorens's (1989) work on adults with cerebral palsy, Hinojosa's (1990) study of mothers of children with cerebral palsy, Kielhofner's (1981) work on deinstitutionalized adults with developmental delays, Hasselkus's (1988, 1989) research on adult caregivers of elderly persons, and Kretting's (1989b) research on reintegration of adults with brain injury into community life.

Ethnography is meaning-centered. Gregory Bateson wrote "nothing has meaning except it be seen in some context. It is the relationship between the parts, the pattern by which they connect within a spatial, personal, and temporal context that give meaning to an individual's life" (McCuaig & Iwama, 1989, p. 75).

Illness Versus Disability

The emphasis on meaning in ethnographic assessment is reflected in the distinction between illness and disease (Kleinman, 1978), one of the foundations of medical anthropology. Disease, with its biological connotation, refers to abnormalities of structure and function of body organs and systems. It is a deviation from the norm in biological processes and, as such, has been objectified and divorced from social and environmental contexts.

Illness is what people experience and is shaped by the culture of the person. As defined by Kleinman (1978), illness is the experience of devalued changes in being and in social function. Illness primarily deals with personal, interpersonal, and cultural reactions to sickness. It is shaped by cultural factors such as how one is socialized to react to pain and how one expresses discomfort. The experience of illness can also be based on social position, on previous illness experience, and on one's attitudes about certain illness labels or diagnoses.

Clients may be socialized to identify disease-related problems when interacting with health professionals and to report disease symptoms even though they may not be a priority. Krefting experienced this in a recent research project dealing with recovery after traumatic brain injury (TBI). When she was identified to TBI persons with disabilities and their families as an occupational therapist, the problems that were identified as critical were double vision, unstable walking, and swallowing difficulties. On other occasions, when she was identified as an anthropologist, the problems they identified were lack of finances, loneliness, and being labeled as retarded. Thus clients may verbalize the disease aspect of their discomfort according to their perceptions of role expectations of health professionals even though their illness difficulties may be perceived as more troublesome.

Some scholars assert that there has been systematic inattention on the part of health professionals to the illness aspect of disability and that this is in part responsible for noncompliance, client and family dissatisfaction with health care, and inadequate clinical care (Kleinman, Eisenberg, & Good, 1978). Although occupational therapy philosophy is client-centered and holistic, the realities of practice may press the therapist to deal with problems of disease. Since standardized assessments are often designed to gather disease-related information, the use of ethnographic assessments, which identify more illness-
related information, may help therapists become more sensitive to the client’s interpretation of the illness or disability and may help establish assessment and treatment priorities accordingly.

Application of Ethnographic Research Methods for Use in Clinical Assessment

We believe that ethnographic research methods, which are traditionally time-consuming and labor-intensive, can be adapted for practical use in clinical assessment because of the two fundamental similarities between ethnographic methodology and the traditional assessment process in occupational therapy. In both, observations constitute evidence from which conclusions are drawn systematically. That is, on the basis of a variety of specific details that we observe and document, we formulate an integrated picture of the client’s functioning. Additionally, in both approaches, initial hypotheses are formulated about the client based on assessment, and these hypotheses are refined and revised on an ongoing basis as we make additional observations about the client during treatment and reevaluation. Thus, we use new data not only to test the reasonableness of the picture of the client that we initially developed but also to revise it as appropriate.

There are, however, important differences between the occupational therapy assessment process and the ethnographic tradition. The goal in ethnography is always to view individuals within the context of a culture or subculture. Ethnographers have a strong commitment to conducting observations (or gathering evidence) in the real world of the person rather than in some special testing or clinic environment. Further, ethnographers interpret evidence and draw conclusions within the framework of the real world being observed rather than from their own world. Thus, to incorporate ethnographic assessment as a clinical tool in occupational therapy, we would need to develop ways to gather data about the real world of the client, and we would need to judge client performance by his or her real world standards rather than by comparison with some abstract reference group of persons who have been part of a test standardization process. Ethnography allows a perspective on cultural norms for performance and thus a more realistic and thorough analysis of the quality of client performance relative to expectations within the setting.

Comparing Standardized and Ethnographic Assessment of Self-Maintenance Occupations

These similarities and differences between traditional occupational therapy assessment and ethnographic assessment may become clearer if we compare their use in the assessment of the task of food preparation. In the typical occupational therapy assessment, food preparation tasks are used as a means of examining performance components including sensorimotor, perceptual, and cognitive capabilities: or as a means of examining meal preparation skills to determine whether clients are able to prepare their own food, an important survival capability, in the kitchen space they will be using at home.

A number of questions about food preparation are not addressed in these assessments, yet seem crucial to understanding food preparation within the overall context of the client’s daily life. One of the most important questions is how the food gets into the cupboards and refrigerator. Therapists usually start with the assumption that food is already there and worry about whether clients can reach and manipulate things within the kitchen space. The task of obtaining food to stock the cupboards and refrigerator is a community-scale problem, one that is often far more difficult for persons to manage than manipulating the food once it is in the home. An examination of how food is obtained might involve finding out how the person gets to the grocery store and back with a heavy load and whether there is an alternative place he or she might go within his or her territory that would be easier. The examination might involve finding out whether the client has the social skills to work out reciprocity arrangements so that a family member or neighbor will take him or her to the store or bring food to the client’s home. These community-scale issues have been the focus of a line of research in occupational therapy at Texas Woman’s University in which we have compared the use of neighborhood environments by elderly persons from different cultural backgrounds including persons of African-American, Caucasian, Chinese, Hispanic, and Vietnamese descent. Not surprisingly, we have learned that many alternative ways exist for solving common adaptive community-scale problems.

Another important issue in examining food preparation within the larger context of the person’s daily life is to consider how this occupation is generally organized within the person’s culture. For many persons, food preparation is part of a much larger network of cooperative arrangements for managing the economic unit of the household, and in extended families, this network may involve a large number of people. The client’s direct role in food preparation may be large or minimal, and it may be possible to trade off aspects of this role for other responsibilities within the larger household management system. We found major differences in household management patterns in the Neighborhood Environments Project in Houston. Subjects from Caucasian backgrounds tended to live alone or with spouses and tended to organize household management in a pattern we termed independent-autonomous. Subjects from other backgrounds, including African-American, Chinese, Hispanic, and Vietnamese cultures, tended to manage households using an interdependent pattern in which a number of persons were involved, including family mem-
bers and sometimes neighbors. It is important to recognize that not all persons practice or value the personal independence we tend to expect of clients in occupational therapy. These differences may have important implications for how therapists think about meal preparation capabilities in clients whose expected household management pattern is quite different from that of the therapist.

In addition, it may be important to examine the meanings associated with preparation and consumption of food for the client. Such meanings may play a major role in a client’s family or social life, with meals serving a kind of ritual function in anchoring relationships. This may be true for meals eaten at home, and it also appears to be associated with eating at restaurants for many people. The cultural meaning of the activity may also dictate how important it is to do the tasks and to what degree of elaboration they are carried out. For example, if cooking is seen as a gift or a sign of caring, the person is likely to put a great deal of effort into the activity, perhaps more than the therapist might think necessary. An energy conservation program that suggests the use of a microwave oven to prepare food would not be acceptable to someone who spends 2 days preparing lunch for guests.

A Proposed Ethnographic Assessment Process

An ethnographic assessment process in occupational therapy practice might involve the following steps, which could be summarized in a narrative report:

1. Define the unit of study: If the goal of ethnographic assessment would be studying the individual in context, then establishing the relevant context that will constitute the unit of study is an important initial step that will guide further data gathering and interpretation. An inability to define the unit of study is a common problem and it is easy to take on too much. The relevant context or unit of study should be defined situationally, based on the life circumstances of the client and his or her daily round of occupations or intended occupations. The context might be a work setting, an extended family household, or a neighborhood within which the person travels to manage daily routines.

The unit of study for occupational therapy clients will often lead to a focused ethnography, that is, a problem-centered examination of a specific occupation within the daily context in which it is performed. However, there may be situations in which an overview of the person’s entire constellation of occupations is the appropriate unit of study. An integrated perspective on overall occupational functioning may be particularly applicable at times of major life transition when fundamental changes in the client’s entire occupational constellation typically occur, such as sudden onset of major disability or death of a spouse.

2. Describe the culture of this unit: Many definitions of culture exist in anthropology, but in general, cultures are considered as having material, social, and ideological aspects. Considering the culture, or more properly the subculture, of the context used for ethnographic assessment involves attention to all three of these domains. A description of the subculture of the context chosen for assessment may thus involve the following:

- The material domain: A description of how occupations such as work routines or household management tasks are regularly performed in this domain, including the settings in which they are enacted and the objects that are used
- The social domain: A description of roles and relationships that organize performance of these occupations (who does what and how they are related)
- The ideological domain: An examination of meanings of occupations (how occupations and performance are valued)

3. Analyze the functioning of the person in this context: Analysis includes observations about occupations or tasks the person did well and those he or she did poorly. Evaluative judgment of the client’s functioning would be based not on comparison with an abstract reference group but with the expectations of persons within the context for how occupations should be performed and with the expectations of the person. Analysis also includes observations about circumstances that appeared to affect client performance, such as observations that the client was less anxious and more adept socially when a supervisor was not present in a work setting, or observations about times of day that facilitate or hinder client mobility in the neighborhood. This information provides valuable clues about the quality of client performance and identification of factors that affect quality. A creative use of the environmental context in an ethnographic assessment might be an interview with a peer of a person with brain injury. Although not the perfect reference point, the interview would provide information on the client’s pre-injury life-style, which is probably the lifestyle to which that person now wants to return. An interactive interview between the person with brain injury, a close friend, and the therapist about favorite activities, worst memories, and so forth might also be useful in an ethnographic assessment.

4. Develop goals for intervention in the person or in the context: In the case of ethnographic assessment, intervention goals are likely to focus on potential changes in the context as well as in the person. Such goals could include determining interventions that prompt coworkers to examine their responses to colleagues with disabilities, brainstorming to help clients develop new sources of social support that might make it easier to get groceries, or helping members of an extended family plan how changes in roles might be accommodated within
their system of household management. During this step it seems crucial to develop hypotheses about expected outcomes of proposed changes, including an effort to anticipate any negative consequences, so that these can be considered in decisions about making change. Barris, Kielhofner, and Watts (1986) used the term environmental managers to describe the role of therapists in regarding the context as well as the person as potential targets for intervention.

Gathering and Interpreting Data

As a research method, the ethnographic approach is inductive, intended to generate new research questions (Leininger, 1985). As a method of assessment, the inductive ethnographic approach assumes that not all is known about parameters of assessment, that important variables have not yet been identified and must be discovered. A more standardized approach to assessment usually focuses the therapist's attention on specific performance components or performance skills and, in following a standardized format, the therapist may miss valuable data.

In ethnographic research, data are gathered through participant observation, interviews, and document review. Because it affords the most direct view of what occurs in that setting, participant observation of ongoing performance within context is highly desirable. Participant observation is sometimes impractical because of time constraints or because clients' settings are located far from the facility. In such cases, unstructured or semistructured interviews can be used to construct a picture of the client's daily life. It is desirable, when feasible, to include interviews with other persons who are part of the context, in addition to those with the client. This permits triangulation of data, or gathering and comparing information from multiple perspectives (Guba, 1981). Review of documents in ethnographic data collection can include diaries, essays, and photographs rather than the results of evaluations completed by other professionals. Data may be gathered by asking persons to tell stories about aspects of their lives, which are then interpreted as narratives. A study of therapists' practice in school settings by Niheues, Bundy, Mattingly, and Lawlor (1991) illustrated use of this method on a relatively small scale; a study of therapists' clinical reasoning used narratives in a large-scale and relatively long-term research effort (Mattingly & Gillette, 1991).

In ethnographic research, the processes of data gathering and interpretation are interwoven rather than sequential, as in other kinds of research. This means that interpretations are formulated on an ongoing basis. The goal is to use further data collection as a way of testing hypotheses about what is going on as these interpretations emerge. It is important to document initial interpretations in writing because, as the process evolves, it is easy to forget the route one took in evolving a picture of the client in this daily context. The logic of this method of testing interpretations is that one purposely looks for data that would cause one to question or revise initial interpretations, as well as for data that support one's initial picture (Pelto, 1970). This suggests that it is desirable to have the process of data gathering and interpretation occur over time so that interpretations can be revised and refined.

Advantages and Disadvantages of Ethnographic Assessment

Although ethnographic assessment can be a useful tool for understanding client performance in the person's daily context, this approach has inherent characteristics that make it inappropriate for some situations. The limitations of ethnographic assessment look surprisingly like the strengths of standardized assessment. One such limitation is reactivity bias: the presence of an observer makes the environment less than natural both for the client and for the co-workers or family. The therapist needs to consider his or her active involvement in the process as an opportunity to confront and analyze the more elusive aspects of social behavior in its natural setting, including his or her own role. Reactivity bias seems particularly important when ethnographic research assessment methods are adopted as part of clinical processes in which the therapist is more than an observer or researcher and is also an active initiator of interventions.

Another limitation in using an ethnographic approach is its lack of standardized procedures. The quality of the assessment thus depends on the perceptiveness and skill of the therapist. The lack of standardized procedures raises questions of credibility, particularly when occupational therapy assessments are read by professionals from other disciplines who may lack an appreciation of thinking about performance in context. One way to support use of an ethnographic approach is to explain the assessment methods, the rationale for their use, and a brief history of the assessment process (Kielhofner, 1981). The reader can then judge the truthfulness of findings and their usefulness in planning interventions. The credibility of ethnographic methods in research seems to be increasing in several health care disciplines including nursing, occupational therapy, and some fields of medicine, and this may increase their credibility as clinical tools.

An additional limitation of this approach is its potential impracticality. Some funding sources prohibit therapists from doing home or community visits, which makes direct assessment of the client in his or her daily context unfeasible. Alternative ways to gather information grounded in the daily life of the client have been suggested, including interviewing persons from the context, use of stories, and use of documents. It is desirable to begin such an approach early in the therapeutic process, rather
than waiting until discharge is imminent. The ethnographic assessment can then evolve over time. Research on efficient ways to conduct and document ethnographic assessment is needed.

Although not useful for all situations, ethnographic assessment seems to have value when it is necessary to assess the individual in context; for example, with clients who have complex disabilities, such as multiple handicaps; with clients who have disabilities that are particularly visible and socially stigmatized, such as disfiguring burns or major speech difficulties; with clients who are preparing to return to the community or to new environments, such as moving from a long-term psychiatric hospital to a group home; or with clients who have ethnic identities and cultural backgrounds that differ substantially from those of the therapist. In such cases, ethnographic assessment offers the advantage of viewing occupational performance in context. This perspective allows the identification and analysis of factors that affect quality of performance, as well as of examining meanings. The result is a better understanding of ways to improve degree of engagement in occupations valued by the person. ▲

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