Doing Occupational Therapy: Dimensions of Satisfaction and Dissatisfaction

Betty Risteen Hasselkus, Virginia Allen Dickie

Key Words: professional practice • qualitative method

Objectives. A phenomenological study was conducted to gain understanding of the nature of the lived experience of doing occupational therapy.

Method. One hundred and forty-eight occupational therapists nationwide were asked to describe especially satisfying and dissatisfying experiences of practice. The resulting narrative data were analyzed with dimensional analysis techniques.

Results. With the metaphor of therapy as story, three overarching dimensions of practice were derived from the narrative data: Change, Community, and Craft. The dimension of Change is strongly related to the ending or outcome of the story. Community encompasses the harmony or disharmony of the interrelationships in the shared story, and Craft includes both the skills of therapy and the broader core experience of doing therapy.

Conclusion. These findings are complementary to the three-track mind discussed in the clinical reasoning study and contribute further to our understanding of the experience of doing occupational therapy.

The American Journal of Occupational Therapy

The purpose of this study was to gain understanding of the nature of satisfying and dissatisfying practice in occupational therapy. The study has significance on two levels: interpretations of the data will provide better understanding of our practice and the dimensions that constitute practice, and the data will further the body of research on work and the experience of work. The fundamental phenomenological question in this study was "What is the nature of satisfying and dissatisfying experiences in occupational therapy practice?"

Expanding on a method used in an earlier pilot study (Hasselkus & Dickie, 1990), we collected experiential narrative data and analyzed them with the intent of developing a deeper understanding of the phenomenon of doing occupational therapy. This phenomenological approach to the study of the work experience is different from other research on job satisfaction and dissatisfaction in occupational therapy that relies on a priori conceptualizations of job attitudes and job behaviors (Bordieri, 1988; Brolie, 1985; Freda, 1992; Madill et al., 1986; Rozier, Gilkeson, & Hamilton, 1991). These studies focused on the content and context of the job as they relate to job satisfaction, specialty choice, and career patterns. Additionally, Bailey (1990) addressed attrition from the profession and therapists' reasons for leaving the field, again within the framework of job content and context (e.g., excessive paperwork, dissatisfaction with bureaucracy).

In our research design, we asked therapists to recount especially satisfying and dissatisfying experiences, in effect to construct a narrative that represented the lived experience of a situation from their perspective. According to Bruner (1986), storytelling is one of the ways we make our worlds, that is, one of the ways we create realities. Mattingly (1991) asserted that narrative thinking is fundamental to the clinical reasoning of occupational therapists. It is through the creation of stories, or "therapeutic employment," (Mattingly, 1991, p. 598) that therapists are able to understand the patients' illness experiences and to develop and carry out therapeutic programs. Diekelmann (1991) described narratives in nursing as emancipatory and empowering, and useful for revealing what she called the "invisible" part of our practices. "These are emancipatory narratives because they recognize our expertise, help us to know each other, transform our thinking, and help us in creating communities" (Diekelmann, 1991, p. 41).

Method

Van Manen stated that "the lifeworld, the world of lived experience, is both the source and the object of phenomenological research" (1990, p. 53). In this research view, knowledge is not essentially theoretical but instead resides in practice and in our encounters with the world through involved activity (Allen, Benner, & Diekelmann, 1986). Here, we address involved activity through a phe-
nomenological question that asks therapists to describe satisfying and dissatisfying experiences in practice.

Sample

Using a sampling strategy described by Waitzkin (1991), we purchased a random sample of the names and addresses of 200 registered occupational therapists from the Direct Mail Service of the American Occupational Therapy Association (AOTA). The only exclusion criterion was that the therapists live in the United States. Data were successfully collected from 148 of the 200 therapists (74%). Of the 148 respondents, 139 were women and 9 were men. Ages ranged from 24 to 70 years, with a median age of 36 years. There was no statistically significant difference between the study sample and the national 1990 AOTA member survey data on the variables of age or gender. The year of certification ranged from 1952 to 1990. The proportion of advanced degrees in the sample (40 master’s degrees and two doctoral degrees) was significantly greater than that of the 1990 member survey data (df = 2, critical value = 6.00, $\chi^2 = 13.70, p = .05$). Twelve of the responding therapists in the sample were not working at the time of the study. Seven more responding therapists no longer considered themselves to be in occupational therapy. The 129 remaining respondents represented a variety of practice areas including education, administration, pediatrics, schools, rehabilitation, acute care, geriatrics, burns, hand therapy, work hardening, adaptive seating, and mental health.

Data Collection

The initial written mailing to the sample of 200 therapists included a cover letter, a short form for demographic data as described above, and one page for each phenomenological question. The questions were phrased as follows:

Think back over your practice as an occupational therapist and identify one incident or case when you felt especially satisfied [dissatisfied] with the occupational therapy that you provided. Describe that case, including what you did, why you did it, what the outcome was, what was most satisfying [dissatisfying] to you.

A follow-up reminder mailing yielded 32 responses—24 fully completed questionnaires and 8 blank questionnaires (from therapists who declined to participate).

Discouraged by the small response rate, but encouraged by the richness of the data contained in the 24 completed responses, we decided to seek responses from the remainder of the sample by telephone. Interviews were ultimately completed with 123 of the remaining therapists and one additional written response was received. The total of 148 responses consisted of 25 mailed responses and 123 telephone responses. Both written responses and recorded telephone data were transcribed and entered into a computer database for storage and analysis.

Analysis

We began the analysis of data by parallel reading (in which both investigators read independently but coincidentally) of all 24 initial written responses, using the highlighting approach to identify experiential units within each response (Van Manen, 1990). We reflected on the relationships among our own themes, looking for linkages and comparing themes for strength. We then met to compare our independent analyses and reach consensus on the units of meaning in this first level of analysis.

Results of this preliminary consensus and the 24 written narratives were sent to two expert consultants for peer debriefing to identify inconsistencies, to suggest additional interpretations, and to explicate biases. The consultants’ independent analyses resulted in suggested categories and units of meaning that were remarkably similar to ours.

With the input of the consultants, we were able to finalize a code list of categories for satisfying and dissatisfying experiences. In our organization of the data for coding, we treated each story as the unit of analysis; satisfying and dissatisfying responses were unlinked and each was treated as a separate entity. Using the text-oriented data management software program Tally (Bowyer, 1991), we coded the data from all 148 respondents; each of us did half of the responses. Tally allows one to mark a text (i.e., insert a code) in an overlay that forms a separate data file. Phrases or whole texts to be marked are bracketed and then coded with user-generated mnemonics. Each of our categories was represented by a mnemonic code and phrase (for example, longknow was the mnemonic for long contact in therapy; nodiff was the mnemonic for making no difference). Use of this text analysis software enabled us to code large amounts of data with relative ease.

We met again for what Van Manen called phenomenological reflection, or a continuing “conversation” with the phenomenon in question (1990, p. 98). At this point, our codes were separated into groups of satisfying and dissatisfying experiences. During our meeting, we compared, clustered, and synthesized our coded data and emerging themes into unifying concepts, and derived three overarching dimensions from the data: dimensions of Change, Community, and Craft (see Figure 1). The concept of dimensionality includes the “parts, attributes, interconnections, context, processes, and implications” of a phenomenon (Schatzman, 1991, p. 309). All narratives were coded and organized into one or more of these three overarching dimensions. For example, both satisfying and dissatisfying relationships with patients, family members, and coworkers were clustered within Community. Codes of both making a difference and not making a difference were subsumed in the dimension of Change. The process of analysis thus moved from an initial identification of many categories and concern with individual
<table>
<thead>
<tr>
<th><strong>CRAFT</strong></th>
<th><strong>COMMUNITY</strong></th>
<th><strong>CHANGE</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MNEMONICS</strong></td>
<td><strong>PHRASE</strong></td>
<td><strong>MNEMONICS</strong></td>
</tr>
<tr>
<td><strong>Satisfied</strong></td>
<td></td>
<td><strong>Satisfied</strong></td>
</tr>
<tr>
<td>GPS</td>
<td>Good problem solving</td>
<td>Collab</td>
</tr>
<tr>
<td>Otish</td>
<td>Using skills, training</td>
<td>Liking</td>
</tr>
<tr>
<td>Initiat</td>
<td>Initiative/perseverance</td>
<td>Longknow</td>
</tr>
<tr>
<td>Effect</td>
<td>Effective, competent</td>
<td>Medlife</td>
</tr>
<tr>
<td>Creat</td>
<td>New twist, inventive</td>
<td>Flow</td>
</tr>
<tr>
<td>Flow</td>
<td>Sense of flow</td>
<td>Match</td>
</tr>
<tr>
<td>Overcome</td>
<td>Overcome obstacle</td>
<td>Valued</td>
</tr>
<tr>
<td>Tangpos</td>
<td>Tangible difference</td>
<td>Patsat</td>
</tr>
<tr>
<td>GPS</td>
<td>Good problem solving</td>
<td>Overcome</td>
</tr>
<tr>
<td><strong>Dissatisfied</strong></td>
<td></td>
<td><strong>Dissatisfied</strong></td>
</tr>
<tr>
<td>Helpless</td>
<td>Can't help or figure out</td>
<td>Used</td>
</tr>
<tr>
<td>Nopoint</td>
<td>OT pointless</td>
<td>Control</td>
</tr>
<tr>
<td>Thwart</td>
<td>Blocked, skills unused</td>
<td>Novalue</td>
</tr>
<tr>
<td>Inadeq</td>
<td>Questions own skill</td>
<td>Devalue</td>
</tr>
<tr>
<td>Harm</td>
<td>Causing harm</td>
<td>Dislike</td>
</tr>
<tr>
<td>Moral</td>
<td>Not morally right</td>
<td>Noteam</td>
</tr>
<tr>
<td>Right?</td>
<td>What is best goal?</td>
<td>Thwart</td>
</tr>
<tr>
<td>Systlack</td>
<td>System lacks resources</td>
<td>Openwar</td>
</tr>
<tr>
<td>Fault</td>
<td>At fault for big negative difference</td>
<td>Unpleas</td>
</tr>
<tr>
<td>Feelharm</td>
<td>Feeling harmed, losing</td>
<td>Right?</td>
</tr>
<tr>
<td>Unable</td>
<td>Not able to do what is right</td>
<td>Nound</td>
</tr>
</tbody>
</table>

**Figure 1.** Dimensions of occupational therapy practice

distinctions to grouping categories into a limited number (three) of broad dimensions. At this point, we returned to an in-depth focus within the dimensions. Ultimately, we each incorporated the cases the other had coded into our analysis for comparison and final interpretations. In the results reported here, we have occasionally made minor changes in the therapists' stories to protect the anonymity of the respondents.

**Results**

Storytelling, (sometimes referred to within the field as *emplotment*), is the ordering of a succession of events into a narrative whole with a beginning, a middle, and an end (Kermode, 1967; Ricoeur, 1984). The wholeness of a story is not dependent on a chronological unity of time but rather on a “dramatic unity” (Ricoeur, p. 39) that relates the story's events to one another. In this study, the therapists' stories often began with a description of the medical and social contexts of a clinical situation as first encountered, then moved through actions that were taken, and concluded with a discussion of the results. This concept of evolving events as the dramatic glue of a story fits Ricoeur's notion that the magnitude of a story must be sufficient to permit change to come about across a sequence of events.

According to Kermode (1967), the beginning and the middle of the story exist “under the shadow of the end” (p. 5). It is the end of a story that gives the story significance and its sense of harmony or disharmony. Kermode wrote that we have a deep need for intelligible ends, for completed action, for attaining the ending that is implied by the beginning. Endings that are surprises or that represent reversals of expected change are perceived as discordant. In such instances, although the dramatic glue of the story is still present (the story's events are logically linked in the drama), the wholeness of the story represents what Ricoeur called “discordant concordance” (1984, p. 42). Concordant and discordant stories are analogous to satisfying and dissatisfying experiences in practice.

**Stories of Change**

The dimension of Change is strongly linked to the end of the therapists' stories; it figures prominently as a sense of satisfying or dissatisfying closure in the experience. Satisfying change was strongly linked to regaining capabilities and social contexts that existed for the patient before the disability. Alternatively, change within dissatisfying practice included a therapist's sense of being unable to bring about any change or as much change as originally hoped for, or bringing about improvement but having that change subsequently undone. More rarely, therapists told
stories of feeling responsible for harmful changes in their patients; for some, the accompanying sense of dissatisfaction was manifested in dramatic personal consequences such as quitting a job or leaving the profession.

For both satisfying and dissatisfying stories of Change, the severity of the patient’s disability (physical, social, intellectual) seemed important to the beginning of the story and the story’s ultimate meaning. Terms and adjectives that resonated with extremes (the patient was “totally nonfunctional” or “needed to be taught everything”) emphasized the seriousness of the patient’s initial impairment.

The middle portion of the stories of Change were tales of perseverance, frustration, and dealing with barriers. “We spent a lot of time,” “we really worked hard,” “and we had to really fight” are phrases that illustrate this experience of struggle as therapists sought to bring about change in or for their clients. Therapists, apparently, do not expect change to come about easily, but they do expect change to come about! Being able to help the patient regain previous capabilities in daily activities is the end implied by the beginning in therapeutic stories. Therapists will try and try to bring about that expected ending.

When the battle was won, and the therapist felt that he or she had contributed to the resulting positive change, the end of the story brought great satisfaction. The greater the struggle, the greater the sense of satisfaction.

I guess the ones that stick in my mind the most are the ones I had to fight in order to help . . . [the patient] was a young fellow who was a telephone line operator who was, you know, kind of zapped off the wires and fell and broke his neck and he really was going to be totally nonfunctional without this brace [CO2 flexor hinge splint]. I had to drive him to [another state] to get it. And it took many weeks of negotiating and convincing the rest of the rehab hospital that if we said we were a rehab hospital and we were going to say we could provide care, that we had to do it; and against much frustration from the powers-that-be, they finally agreed to let me have the hospital van for the day. And we drove to [the other state] and I introduced the patient to the rehab facility and the brace and got him a functional life . . . . I can still see that. I can still be in the van with him, driving there, knowing that I was getting him to the right place.

In this narrative, the therapist brought about a succession of changes—first in persuading the “powers-that-be” to collaborate with her plan, and second in enabling the patient to get “a functional life.” When the battle was lost, however, the story was one of dissatisfaction. A lost battle meant a story that ended without the expected change, without the return to prior functional life. A therapist might see this lack of change as evidence of his or her own inadequate skill, as inability to persuade the management or the patient or the family of the value of the therapy, as running up against roadblocks such as reimbursement policies that were beyond the therapist’s control. Sometimes a patient’s improvement plateaued much earlier than the therapist expected and the therapist expressed dismay that the change was less than he or she had hoped for. Sometimes a patient initially showed satisfying improvement, but the gains were later totally undone by lack of follow-up or by the patient’s death.

This was a particular lady in her middle 30s and she had something close to Lou Gehrig’s disease. . . . we had worked and worked with her. She was losing all the intrinsics of her hand and becoming more and more dependent on other family members to care for her. When she came into the rehab center, we had her convinced that she needed to try to do as much as she could and we got to where she could feed herself, bathe herself, everything with stand-by assist to no assist. Once she got home, her husband ended up doing a bunch of things for her. She became depressed and is now back to maximum care. She is entering a rest home. And that was real sad because you worked and worked and worked with her and got her to where she could do these things and then the family thought they were being a benefit to her by helping her out and that just made her slide backwards.

Overall, this inability to make any difference was the most telling theme of dissatisfaction in stories of Change.

A sense of bringing about a negative change, that is, of actually causing harm to a patient, was less commonly described. When it occurred, however, harm to a patient was recounted in terms of anguish, and dramatic consequences for a therapist’s practice were sometimes revealed. Bringing harm to a patient is the quintessential example of an unintelligible ending to a therapeutic story. The violation of our code of ethics to do good and do no harm appears to create a values encounter within the therapist that mandates resolution. Sometimes that resolution takes the form of a career shift, such as the therapist quitting work, taking a 3-month break from the job, changing his or her area of practice, or leaving the profession.

I was part of a multidisciplinary cardiac rehab program. I provided bedside programs of exercise specific to the patient’s cardiac level to increase endurance and independence in ADLs (activities of daily living). After 5 minutes of working with one patient, he coded and did not survive. I always wondered if the activity I had him do could have contributed to his death. I had reported heart arrhythmias to nursing during treatment and they advised me that this was not unusual for this patient and to continue treatment. Since this experience, I have always preferred not to work in cardiac rehab or in an ICU.

At times, harm to a patient took a more political form. For example, health management policies that pressured therapists to increase patient loads led to therapists’ dissatisfactions with the quality of care they were providing. Being part of clinical situations that were perceived to place the patient’s welfare secondary to the institution’s welfare led therapists into face-to-face confrontations with questions about the meaning of occupational therapy, about right and wrong in health care, about moral and immoral and amoral acts. In such situations, occupational therapists might direct their energies to bringing about changes in the system, with varying degrees of success.

As the director of the general medicine and surgery facility of a hospital. . . . I discovered that the administration was charging a 500% markup on any ADL item that were below $5, a 500%
and expectations, mutual views of the present, and hopes for the future. Community seems to be enhanced when the therapist identifies personally with the patient, such as when the patient is near the therapist’s age or has children of the same age. Further, Community seems to be enhanced when the therapist, patient, and other members are together in a story that extends over a long period of time.

I was working then as a team member in an early education program in the school district. This little cerebral palsy boy was like 2 or 3 years old. I helped get him more mobile because I was in the classroom setting and the family was very willing to cooperate, you know, with ideas and so forth. The physical therapist started coming to school so that we could really and truly be a team with education and medicine. I was instrumental in helping the family sort out that the child would need an electric wheelchair and helped the family fight with the health insurance company to get that wheelchair. I now see that little boy whipping up and down the halls in that wheelchair and he’s walking with a walker because of what we gave them in school as a team, and the family was able to persevere.

A sense of being appreciated, of feeling special, and of deeply caring and being cared about were other themes within Community.

They felt like, and treated me as if I was some kind of miracle worker. . . . It probably has a lot to do with the personalities, the parent and the child and how they mesh with yours and how much you personally kind of emotionally invest in some clients more than others.

At times, the therapist overcame barriers to Community by changing elements of the story to create a mutually satisfying moiré. Developing teamwork where none existed, persuading a supervisor to consider a different view, and overcoming resistance to new treatment approaches were examples of therapists’ successes at building community. These experiences were often part of the battle portion of the Change dimension, such as in the example above of the therapist who “helped the family fight with the health insurance company.” In these stories, the creation of Community within the therapist’s work environment enabled the therapist eventually to bring about change.

The sense of collaboration and active engagement of the client and family seemed to be a strong source of satisfaction in Community. The patient’s or family’s own display of initiative in coming up with ideas and problem solutions became a source of inspiration to the therapist.

We did a lot of neat adaptive equipment and he actually helped to design some of his own equipment. He was real mechanically minded and knew what he was looking for. We would work on things together that way. We developed adapted fishing equipment for him and all kinds of other stuff. I think that’s what made it really fun, was that he was also taking a real active part in his therapy.

At times, the patient’s engagement was especially commandingly, moving the therapist beyond the role of collaborator to that of observer in a drama acted by the patient.

He was just incredible, totally incredible. It took a lot of work on
his part... I perhaps got him started on it, but he really worked a lot on his own and that motivation was there.

In contrast, the superimposition of multiple stories might not result in a satisfying moiré but, instead, may yield a dissatisfying narrative consisting of a jumble of persistently discordant beliefs and expectations, all vying for preeminence and command over the new story. In such a case, when members of the community cannot create a harmonious story, Community is weak and becomes a case, when members of the community cannot create a dissatisfying narrative consisting of a jumble of persistent errors.

In contrast, the superimposition of multiple stories might not result in a satisfying moiré but, instead, may yield a dissatisfying narrative consisting of a jumble of persistently discordant beliefs and expectations, all vying for preeminence and command over the new story. In such a case, when members of the community cannot create a harmonious story, Community is weak and becomes a case, when members of the community cannot create a dissatisfying narrative consisting of a jumble of persistent errors.

In contrast, the superimposition of multiple stories might not result in a satisfying moiré but, instead, may yield a dissatisfying narrative consisting of a jumble of persistently discordant beliefs and expectations, all vying for preeminence and command over the new story. In such a case, when members of the community cannot create a harmonious story, Community is weak and becomes a case, when members of the community cannot create a dissatisfying narrative consisting of a jumble of persistent errors.

In contrast, the superimposition of multiple stories might not result in a satisfying moiré but, instead, may yield a dissatisfying narrative consisting of a jumble of persistently discordant beliefs and expectations, all vying for preeminence and command over the new story. In such a case, when members of the community cannot create a harmonious story, Community is weak and becomes a case, when members of the community cannot create a dissatisfying narrative consisting of a jumble of persistent errors.

Therapists' struggled with feelings of personal rejection when confronted with such responses. One such narrative ended with the therapist's statement, "I felt like a failure as an OT."

Stories of Craft

Craft is a dimension of meaning that calls to mind the craftsperson or artisan, someone with a great deal of skill and a love for the task. Narratives that include the Craft dimension focus on what the therapist did, or on the process of doing. This dimension first became apparent to us in stories that did not fit the sequence described in Change and Community. In Craft stories, the therapist might be the primary or sole character. The stories may lack any specified patient or client, or may include the patient only as an object of the action of the therapist. The narratives focus on tasks that the therapist found enjoyable, or skills and knowledge that were personally important. In the dissatisfied dimension of Craft the narratives concentrate on lack of knowledge, skill deficits, or errors.

At the most elemental Craft level, therapists spoke of enjoyment of some modality of their work: "I love making splints, especially dynamic splints, so anytime I have the opportunity to make a dynamic splint, I really enjoy that." Therapists told of "being on the cutting edge of prosthetic research" and of enjoying challenges to their skills. First experiences of applying treatment strategies learned in school were memorable:

In school you get all the theory and you get some chance to practice, but this was actually putting everything into practice. So that was my first real experience with seeing theory applied to practice. So that was exciting.

The pleasure of learning new skills and of gaining recognition from other people when they did a good job were also part of this basic Craft dimension.

Conversely, therapists were dissatisfied when they felt inadequate in their skills, for example, "not having the neurodevelopmental background" to provide needed treatment, or having to fabricate a splint and feeling unsure how to do so, or "feeling like I didn't have the tools and the knowledge to really help the patient achieve the goals." One therapist told of being hit by a patient and blaming herself for the patient's action: "I'm not feeling I really handled the situation the best I could. Like if I could have prevented her from striking out. So there was a lot of guilt there." A patient's suicide left another therapist feeling responsibility for "not being good enough to make it better." This sense of inadequacy might be derived from perceived personal shortcomings, such as lack of education or experience, or from unreasonable situational demands, such as inadequate supervision.

Dissatisfaction with the Craft aspect of one's work sometimes included a public dimension. One therapist still remembered causing skin damage to a patient with a spinal cord injury while she was a student: "That was a humiliating experience, even though the other OTs had said it's happened to them... it was a small blister but it was always brought out in the team meeting, that it was still there." The need to call in a supervisor or another therapist to help solve a technical problem was an additional public source of dissatisfaction.

We began our dimensional analysis with a specific and limited sense of the meaning of Craft. Well into the analysis, however, we discovered another level of Craft that was much more inclusive. At this deeper level, the therapist relates a story of skillfully orchestrating a complex series of interventions, all leading to a successful
outcome. These are complicated stories in which the therapist demonstrates expertise in multiple contexts, using a variety of abilities. These narratives have a sense of completeness, though they often lack a sense of high drama because the focus of the story is on the process, or middle, rather than the beginning or end. No particular act of the therapist may be exceptional; rather, it is the accumulated effect of a series of actions and decisions that make up a treatment experience that seems to be particularly satisfying.

In these narratives, therapists tell how they apply their technical skills and simultaneously develop relationships with patients and families, negotiate with complex systems, and smooth paths to enable all of those involved to make progress. What sets these cases apart, or seems to make them satisfying, is their completeness. The success is spoken of in terms of the patient’s general well-being.

One complex story focused on a man whose hand had been crushed in a work accident. The therapist described wound management, control of edema, use of a pressure glove and pneumatic device, debridement, and splinting during the early stages of treatment. This treatment was followed by work on hand function and a successful work-hardening program:

That was probably my most successful case because I was able to follow it from such an early onset and watch him return to work. He was responsible for four small children and a wife who did not work, and therefore, financially, it was very important for him to return to work as soon as possible. And he returned full capacity, full-time to his previous employment.

Clearly, these stories represent dimensions of Change and Community as well as Craft, but the competency of the therapist is predominant throughout each narrative. Other narratives represent this Craft dimension even though the improvement and future outlook of the patient is less dramatic. A therapist working in a long-term care facility was able to improve a resident’s overall well-being:

I discovered that she liked to crochet and that was a great hobby of hers and she crocheted items for some of the other residents and also made dolls that were sold for the fundraising project. That was something she wanted to be able to continue to do . . . I gave her some adaptive devices . . . we tried different types of things . . . within a short period of time she had decided on which devices were best for her and was successfully able to continue her crocheting and also to participate in her activities of daily living without any assistance . . . . It was a satisfying experience for me, to help someone to be able to be independent in self-care and to pursue her leisure activities, although I didn’t do anything to improve her strength.

This aspect of the Craft dimension was also experienced in working with groups. A therapist working with a group of adolescent girls recalled a project that took months of work:

They were feeling the lack of ability to work and earn money for themselves to buy Christmas presents for their families . . . and so they set some goals for themselves to do some projects—baking and raising plants and craft projects—and have a sale . . . they learned baking from me and the foster grandmother . . . . We worked with the business education teacher who allowed us to borrow the cash register and we taught them the appropriate manners for being a sales clerk . . . . at the end they felt very good about themselves. They had control. They had the ability to make decisions, they learned to work through some conflicts, they learned how to communicate better with their parents . . . . It was something that really felt good to me and I look back on it as a Herculean effort that required a lot of jumping through hoops and getting administration to cooperate and a few other things, but it was really a pleasing project.

Discussion
Dimensions of Satisfaction and Dissatisfaction

Geertz (1973) proposed that one arrives at some understanding of the meaning of a situation through peeling back layer after layer of thick description. The cases we studied were often rich in description as therapists told detailed stories of satisfying and dissatisfying practice incidents. In peeling back the layers of detail, dimensions of Change, Community, and Craft emerged and were sufficient to categorize all cases. Further analysis of each dimension revealed characteristics of the stories that amplified meanings through aggregation of similarities, dissimilarities, and seeming paradoxes. The dimension of Change is perhaps the most predictable theme of meaning. In a pilot study (Hasselkus & Dickie, 1990), we identified making a difference as one of the strong themes of satisfying practice. Sense of initiative was another theme from the earlier data that related to many of the Change cases. The nature of this dimension, as well as the dissatisfaction associated with lack of change or negative outcomes, is further developed in the present study. Viewing the data as narratives makes it clear that the Change dimension relates to the end of the story, or sense of closure. When a therapist is able to facilitate a successful outcome, the story has an intelligible ending and is satisfying, particularly when substantial effort has been applied and the amount of change is great. The lack of change or a negative outcome or failure to achieve closure becomes a dissatisfying memory. Memorable incidents that relate to dissatisfaction with the amount or direction of change in the patient sometimes become turning points or forces for change for the therapist.

The dimension of Community is related to the themes of being valued by others and agreeableness from the pilot study. In the present study, however, we developed the idea that it is the success or failure of the therapist to create a mutually agreeable story with the other parties that is the essence of this dimension. With respect to the patient-therapist relationship, the beginning of therapy often corresponds to that point when the patient has to reevaluate his or her anticipated life story to account for a new disability. The occupational therapist may have a more accurate idea of what is probable and possible at this time than either the patient or family, but the rewriting of life stories is never based entirely on...
reasoning and skill, drawing from all aspects of practice to consider the patient's problems in the context of their personal lives. They manage systems problems and devote time and skill to changing the attitudes of other staff members, the patients, and family members. They look beyond the here and now to the future lives of their patients. It sometimes seems excessively glib or idealistic to speak of occupational therapy's concern with the whole person or of occupational therapists taking a holistic approach. These complex Craft stories demonstrate that, indeed, there are occupational therapists who work holistically, and who remember that holism with satisfaction and pride. Is this perhaps the core of occupational therapy practice, reidentified and reaffirmed in the 1990s?

Clinical Reasoning

Parallels exist between the three dimensions of satisfying and dissatisfying practice and Fleming's three-track mind of clinical reasoning (1991). Whereas Fleming addressed the reasoning processes of occupational therapy practice, in the dimensional analysis of our data we attempt to address the essential nature of the practice.

Fleming's (1991) procedural reasoning strongly reflects a therapists' thinking about disease and disability and treatment activities. Of the three dimensions of practice derived from data in our study, the Craft dimension most closely resembles the procedural reasoning. Craft narratives depend heavily on "chart talk" (Mattingly, 1991, p. 999), that is, descriptions of symptoms, physical and mental impairments, assessment goals, and treatment strategies. This parallel with procedural reasoning is especially evident in the elemental Craft narratives in which therapists seemingly shift into the reporting mode of chart language, sometimes not even mentioning the patient or his or her life context.

Fleming's interactive reasoning is similar to our Community dimension with its strong theme of interrelationships. Fleming referred to interactive practice as "underground practice" (Fleming, 1991, p. 1010) or unreported practice. In our Community dimension, strong themes of working together with a patient and satisfactions derived from that cooperative activity were evident. Additionally, a sense of the patient's or family's active engagement in the new story was especially satisfying, in keeping with Mattingly's concept (1991) of creating therapeutic experiences that mattered to the patient. Community also included the collaboration of health team members and of professionals with family members. These relationships were often the potent ones in the story. The Community dimension was prominent in the narratives, in contrast to the unreported, underground practice of Fleming's interactive reasoning.

The idea of a moiré, the union of many stories resulting in the mutual creation of a new story, extends previous discussions of the ways that therapists and patients work together. Crepeau's (1991) treatise on intersubjectivity and Mattingly's (1991) powerful metaphor of therapy as story focus respectively on the therapist's need to understand the patient's perspectives and on the abilities of the therapist to fit her or his own story into the patient's larger story. To extend these concepts, it appears from our data that therapists, coworkers, patients, and families do, by virtue of these interactions, create a new story that is part of all their lives. This new story is therapy as narrative.

The conditional reasoning of Fleming has parallels to our dimension of Change. Within both conditional reasoning and Change, therapists imagine and describe their patients' past, current, and future social worlds. Fleming described conditional reasoning as an integration of procedural and interactive reasoning, that is, an integration of the chart talk and phenomenology. In our stories, the therapists strove to create with the patient a life after treatment that was as similar as possible to what that life had been before the illness and treatment. When the image of the future was not the same for therapist and patient (e.g., when the patient expressed disbelief in the therapy, refused to carry out treatment plans, or refused to continue to use newly regained skills of independence), the therapist found the experience dissatisfying. When both the therapist and the patient believed in the therapy and shared similar images of the future, bringing about the conditional changes was satisfying.

Study Strengths and Limitations

Our research design is a derivative of Flanagan's critical incident technique (Flanagan, 1954). In this technique, a large number of responses are solicited and persons are asked to describe an incident at the extreme of some aspect of practice or job. Flanagan applied content analysis to his data to develop job performance standards for defense industries and military operations. Herzberg (1966) used a closely related technique to identify factors related to attitudes toward work. We found the narratives elicited with our critical incident question to be equally suited to qualitative dimensional analysis (Hasselekus & Dickie, 1990).

Van Manen (1990) discussed both protocol writing (the generation of written texts by the respondents) and
interviewing (eliciting verbal personal life stories) as data collection techniques in phenomenological research. The written protocol has the risk of including more reflectivity (explanations and interpretations) of the lived experience in the description than the oral interview. In both methods, however, it is necessary to help the respondent stay as close to the experience as possible through careful phrasing of the instructions and questions. As Becker stated, "A good research question evokes memories of events that have been lived through rather than thoughts about the phenomenon" (1992, p. 38). In our study, the interview narratives are less organized and contain more filler than the written responses, but the mnemonics that we derived from the written data applied readily to the telephone interviews without modification.

In our question, we asked therapists to remember an incident that they found particularly satisfying or dissatisfying related to the experience of practice, rather than qualities of the job. In that sense, this study is different from those that address job satisfaction or other questions related to the employment position of the person. Arendt (1958) proposed a distinction between labor and work that provides some added insight into this difference. Labor is the work of the body and is closely tied to survival, while work is performed by the hands and results in the creation of some lasting product. Applebaum (1992) likened Arendt's distinction to "Marx's differentiation between the qualitative aspects of labor (work) and the quantitative aspects (labor)" (p. 492). With this distinction, the studies of job satisfaction tend to focus on conditions related to quantitative acts of labor. The nature of our question resulted in a qualitative focus on work. Therapists addressed aspects of meaning in their work rather than their labor.

Conclusion

The dimensions of Change, Craft, and Community are expressions of our way of being occupational therapists. In phenomenological terms, they are our ways of being-in-the-world (Heidegger, 1962). Our therapy exists in the shadow (or the light) of the end, that is, in our hopes and images of the future and what we will be able to bring about for our patients and for ourselves. We seek throughout our lives to become fully what we are able to be. As occupational therapists, we also seek to enable our patients to become fully what they are able to be. Dissatisfying experiences in practice represent threats and roadblocks to our lifelong process of becoming and to our ability to enhance the becoming of our clients. Sometimes such dissatisfying experiences become a turning point for a therapist, leading to a job change or even a change in professions in order to continue to become. Satisfying experiences contribute to our sense of becoming for ourselves and for our clients. Our image of the future and possible goods is supported. The essence of our being-in-the-world as occupational therapists is made manifest.

The responses in this study were narratives of the work of creating new stories by therapists and patients; these were stories that lasted in the sense that they transcended the time boundaries of the therapeutic intervention itself. The lasting characteristic of a therapeutic story seems to fit historical definitions of work and its products. The therapist performs work and produces a work—a new story and a new future.

Acknowledgments

We thank Susan Rosa, MS, OTR, for her skillful collection and management of the narrative data, and Laura Krefting, PhD, OTR, and Maureen Fleming, EdD, OTR, FAOTA, for serving as consultants in the analysis.

This study was supported by a grant from the American Occupational Therapy Foundation. This manuscript is based on a presentation at the Research Forum of the 73rd Annual Conference of the American Occupational Therapy Association, June 1993, Seattle, Washington.

References


Getting a Grip on Handwriting

A Self-Guided Video and Manual

School-based OTs can use this self-guided video and manual to assist elementary teachers in devising appropriate intervention strategies for children with learning or mild motor impairments.

Learn to work more effectively with educators in teaching children to communicate through writing. This video and manual, by Barbara Hanft, MA, OTR/L, and Dottie Marsh, MS, OTR/L, will give you the knowledge needed to assess the essential components for handwriting and to assist the classroom teacher in devising intervention strategies.

The video includes:
1. Information on hand anatomy and function for writing.
2. Guidelines for determining the motor readiness to learn to print.
3. Case vignettes of three children who have problems learning to print or who have problems learning to write in cursive.


Order #1979 $69.00 AOTA member $79.00 nonmember

To order, call 1-800-SAY-AOTA (members), 301-948-9628 (nonmembers).

Yes! I want to order Getting A Grip on Handwriting.
Order #1979
Name_________________________Member #__________
Address___________________________________________State____Zip_____
[ ] MasterCard [ ] VISA
Card #__________________________Exp. Date__________

Qty.__________ Shipping and Handling
Price__________________________
S/H__________________________$15.01-$30.00 add $4.00
$30.01-$45.00 add $5.00
$45.01-$60.00 add $6.00
$60.01-$100.00 add $7.00
$100.01 or more add 7% to total
MD Tax (5%) ___________ Canada: add 20% to total
(MD residents only) Foreign: add 25% to total

Please send your order to AOTA Products • 1383 Piccard Dr. • P. O. Box 1725 • Rockville, MD 20849-1725