The thinking therapist
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Introduction

The practice of occupational therapy had its beginnings in the wards of long-stay psychiatric institutions, with the first occupational therapists providing systematic programmes of purposeful activity for people who were excluded from society and confined. Many of these institutions contained as many as 2000 or more inmates and they were built on the outskirts of towns (Paterson, 2002), providing a visible indication of the marginalised status of the inmates.

Occupational therapists working in these institutions used interesting, soothing and pleasurable activities to occupy the time and hold the interest of patients: ‘a program of wholesome living as the basis of wholesome feeling and thinking and fancy and interests’ (Meyer, 1977, p. 641). Their aim was to enable patients to discover for themselves how engagement in routines of activity could help them to adapt and learn to manage their mental health problems so that they might become reintegrated into society as productive and worthy citizens.

The purpose of the occupational therapist in treating cases of mental disorder is to provide means for the re-education of those functions of the mind which are either not functioning or are functioning abnormally, i.e.: to train the patient who has lost the power of concentration to concentrate again; to revive lost powers of initiative and to bring the patient who is living in a world of phantasy into touch with real things again; to stimulate and restore confidence in herself in the depressed patient; to engage the mind so that delusions and
hallucinations which distress the patient when her attention is not otherwise held, are for a time driven out.

(Haworth and MacDonald, 1946, p. 10)

This approach to treatment was based on the principle that people have a fundamental need to be active:

> Our conception of man is that of an organism that maintains and balances itself in the world of reality and actuality by being in active life and active use, i.e., using and living and acting its *time* in harmony with its own nature and the nature about it.

(Meyer, 1977, p. 641)

Although the way that society treats people with mental illness has changed, so that there is no longer the same need to occupy people during long hospital admissions, occupational therapy practice is still based on the belief that people are intrinsically active and that their health and well-being are influenced by what they do (Creek, 2003). The American occupational therapist, Mary Reilly, expressed this in the well-known phrase: ‘that man, through the use of his hands as they are energized by mind and will, can influence the state of his own health’ (Reilly, 1962, p. 2). Reilly said that ‘a profession organized around this hypothesis sets few limits to its growth’ (1962, p. 2), and the development of the profession over the past 100 years has not refuted this claim. Occupational therapy has adapted to changing social, political and economic climates throughout its history and has expanded successfully into different cultures all over the world.

The profession of occupational therapy started in the United States, with a group of interested people from different professional backgrounds meeting in 1917 to establish the National Society for the Promotion of Occupational Therapy (Paterson, 2002, p. 8). The World Federation of Occupational Therapists (WFOT) was established in 1952 when ‘a small number of senior members of the profession . . . decided that the increasing growth and strength of the profession warranted and indeed made imperative the establishment of an international body’ (Mendez, 1986, p. 1). The first WFOT Council meeting was held in Edinburgh in 1954, attended by 10 founder member countries. At the beginning of the twenty-first century, WFOT has 60 member countries: 52 full members and eight associate members.

The first British occupational therapist trained in the United States and was employed in Scotland in 1928 (Paterson, 2002). Nearly 80 years later, there are over 26,000 occupational therapists registered to practise in the UK (Health Professions Council, n.d.). In the early days, most occupational therapists worked in
psychiatric hospitals, general hospitals or social services departments. Now, in the United Kingdom, they work in accident and emergency departments, community settings, forensic units, people’s homes and workplaces, primary care clinics, prisons, schools, sheltered housing, in fact, in almost all the places where people live their lives.

This essay discusses the knowledge and skills that an occupational therapist needs in order to practise effectively in all these settings and to fulfil her professional purpose. The first section discusses occupational therapy practice and identifies the core skills of the practitioner. The next section describes three approaches to practice: the practitioner as technician, technologist or thinker. The third section considers the nature of professional expertise and describes the difference between novice and expert technicians, technologists and thinkers. The final section concludes that all three approaches need to be integrated to achieve true expertise in occupational therapy practice.

What does an occupational therapist do?

Human beings have an occupational nature (Wilcock, 1998) therefore, in order to maintain health and well-being, people need to be active and organise their activities into flexible routines that have personal meaning and social value. When someone’s ability to engage in activity and to participate in society is impaired by a health condition or by circumstances (World Health Organization, 2001), the occupational therapist assists him to gain, maintain, improve or regain the skills to support everyday life. Occupational therapy has been succinctly described as ‘the process of finding creative, appropriate and contextually relevant ways of dealing with those life challenges that create the need for intervention’ (Christiansen, 2006, p. xii).

Much of what occupational therapists do is concerned with the tasks and activities of everyday life, which are taken for granted until we cannot perform them because of illness or disability. The goals of intervention can appear commonplace but the approaches used to achieve those goals are sophisticated and highly skilled. Assessment and intervention are tailored to the occupational needs of individuals within the contexts where they expect to live and work (Creek et al., 2005). This means that the occupational therapist must have a broad knowledge base and a wide array of practical skills that can be applied flexibly to suit different problems and circumstances. In addition, she must be able to think carefully and creatively to decide on the best course of action, and that thinking should be a collaborative process with the client and others. Professional judgement is always exercised in a social context and, ‘to be effective, must be dialogical’ (Nixon and Creek, 2006, p. 78).
The practice of occupational therapy utilises a set of core skills (Creek, 2003):

- Building collaborative relationships with clients that will promote reflection, autonomy and engagement in the therapeutic process;
- Assessing and observing functional potential, limitations, ability and needs, including the effects of physical and psychosocial environments;
- Enabling people to explore, achieve and maintain balance in their occupations in the areas of personal care, domestic life, leisure and productivity;
- Identifying and solving occupational performance problems;
- Promoting health, well-being and function by analysing, selecting, synthesising, adapting, grading and applying activities for specific therapeutic purposes;
- Planning, organising and leading activity groups;
- Analysing and adapting environments to increase function and social participation.

These skills incorporate three elements that interact with each other as the therapist assesses, makes judgements, negotiates, takes action and evaluates the impact of her actions:

1. **Practical skills**: the techniques that the therapist has mastered, which make up a personal toolbox. These skills include communication, interpersonal and teamworking skills, skills and techniques for assessment and therapy, time management and self-management skills.

2. **Knowledge and understanding**: the theories that can be used to describe situations, build an explanation for what is happening and predict the effect of different interventions. The knowledge base of the occupational therapist includes concepts, theories, frames of reference, approaches and models. These may be specific to occupational therapy, such as the classification of occupations (Creek, 2002), or have been developed within other disciplines, such as the social model of disability.

3. **Thinking skills**: the mental actions used by the therapist in framing problems and working out the best solutions. The thinking skills of the occupational therapist include clinical reasoning, decision making, reflection, analysis and ethical reasoning.

Practical skills, knowledge and thinking are necessary elements of the practice of occupational therapy but not all practitioners give them equal weight.
Some occupational therapists put more emphasis on their practical skills; some are more concerned with using theory and models to direct their practice, and some see occupational therapy as a complex intervention that requires them to reflect, make case-by-case judgements and negotiate the most appropriate action to be taken at each point in the process (Creek, 2003).

The way that the therapist works will depend on which of these approaches she is using. For example, the practitioner working in mental health, who bases her practice on technical skills, may organise daily programmes of therapeutic groups to which clients are allocated following an assessment of their needs. The practitioner who uses a single model or frame of reference will apply the same process of assessment with each client and formulate his problems within the framework of that model. The practitioner for whom thinking is central to practice sees the client’s mental health problems as part of a wider picture and uses a variety of theories and practical skills to suit particular needs at particular times.

**Approaches to occupational therapy practice**

The early occupational therapists were skilled practitioners, with knowledge of a wide range of crafts and other activities. They were also expert at communicating with their clients and engaging them in carefully planned programmes of activity that would serve therapeutic purposes. An occupational therapy textbook published in 1955 advised that: ‘The Occupational Therapist must have the necessary technical knowledge, special aptitude for imparting instruction, and a suitable temperament and manner’ (O’Sullivan, 1955, p. 28).

Fifty years after this was written, occupational therapy practice still requires the practitioner to have a good range of skills and techniques. The student on practice placement learns generic skills, such as communication, observation, reporting and record keeping, and specific practice skills, such as assessment of motor skills, group facilitation or wheelchair prescription. The beginning practitioner usually concentrates on building up a sound repertoire of skills within the area of practice she has chosen. A good therapist will continue to learn new skills and techniques throughout her career, keeping up to date with social, technological and professional developments.

Some occupational therapists are satisfied that having a good range of practical skills enables them to meet the needs of their clients. These therapists often describe their practice in terms of the techniques they use, for example, ‘I’m a creative therapist’ or ‘I supply assistive devices and recommend housing adaptations’. This practitioner is *the technician*. 
The technician

A technician is ‘a person skilled in the technique or mechanical part of an art or craft’ (*Shorter Oxford English Dictionary*, 2002). In occupational therapy, this is the practitioner who has highly developed practical skills, usually in a particular field or approach to practice. For example, the therapist might have expertise in working with amputees or in using projective techniques.

Every occupational therapist learns a range of generic and specialist practical skills, which will continue to expand throughout her career. The experienced therapist will have more skills, at a higher level of competence, than a beginner. Any change of field will necessitate learning a new set of skills and techniques specific to the new area of practice. The technician may be skilled in a few techniques or many. These may be techniques that are applicable across a range of practice areas, for example teaching activities of daily living, or useful mainly within an area of specialisation, such as stress management.

A qualified occupational therapist is expected to have more transferable skills and a wider range of skills than a support worker. A study of the relationship between qualified and unqualified staff in the remedial professions in the 1970s concluded that an experienced unqualified worker is expected to have practical knowledge of the job but not to have the theoretical knowledge that would make their skills transferable (Alaszewski and Meltzer, 1979). This is not the case in some other countries, such as South Africa, where support workers have both a practical and a theoretical education.

Occupational therapy is concerned with what people do and how they do it; therefore much of the profession’s value and status comes from practical interventions that make a visible difference in people’s lives. However, this does not mean that all occupational therapists practise as technicians: some feel the need to have a more explicit way of understanding the process of change that people go through in adjusting to disease or disability. They seek theories to explain how disease and disability impact on function and indicate what actions might be taken to remediate dysfunction. The practitioner who uses a theoretical framework as a guide for applying knowledge in her daily work is the technologist (Christiansen, 2006).

The technologist

In the first half of the twentieth century, occupational therapists worked under the direction of medical staff, making a clear distinction between the use of occupation as therapy and its use for other, non-curative purposes such as earning money (O’Sullivan, 1955). The doctor provided the knowledge of medical theory that enabled occupations to be used therapeutically: the occupational therapist
provided the practical skills to engage patients in activity. In effect, the occupational therapist was a technician working under the direction of the doctor.

This relationship continued until the late 1950s, when it became apparent ‘that too much emphasis [had] been put upon the diversional and occupational aspects of activities to the neglect of the psychodynamic problems of the individual receiving occupational therapy’ (Azima and Wittkower, 1957, p. 1). The authors of a study of occupational therapy in psychiatric hospitals in North America (Azima and Wittkower, 1957) concluded that this was due, in large part, to the lack of a theory of occupational therapy and to the inability of psychiatrists to perform the expected role of authority. The time had come for the profession to develop its own theory base.

In the early 1980s, the American social scientist, Donald Schön (1983), said that the professions do not only have specialist skills, they also hold specialist knowledge and apply it in order to solve the complex and obstinate problems of society. For example, the medical profession applies specialist knowledge to the cure of disease, with the object of producing a healthy society; the economist assumes responsibility for the economic well-being of society through managing the flow of money, and the teacher is the expert in educating the next generation to the standards set by society. Schön suggested that a rapid increase in the number of professions at the beginning of the twentieth century was directly related to a growing social need for technical expertise.

As the amount of scientific knowledge in the world increases, it becomes more and more difficult for any one person to know everything there is to know in his own area of expertise. This has led to narrower specialisation and a separation of the functions of knowledge creation and knowledge application. The task of producing and testing knowledge now belongs to scholars, researchers and academics, who tend to be employed within universities. The application of knowledge is the job of professionals, who are usually employed in practice positions (Schön, 1983).

Within occupational therapy, research and theory development are mostly carried out by the faculty of universities, while the resultant knowledge is applied by occupational therapy practitioners employed in health and social care contexts. This separation of theory development from theory application has led to a perception, by some therapists, that theory and practice are distinct entities: pre-existing theories can be learned from books and then applied to practice situations. The technical-rational approach to occupational therapy employs frames of reference and models to identify and solve the problems presented by clients. The technologist is a practitioner who works in this way: a person skilled in the application of science (Shorter Oxford English Dictionary, 2002).

The science of occupational therapy ‘is a synthesis of knowledge adopted from many different disciplines together with concepts and theories developed within
the profession and the experience of individual practitioners’ (Creek, 2003, p. 32). The Swedish philosopher, Törnebohm (1991), suggested that occupational therapists require four types of knowledge:

- Knowledge in a wide sense about the world, about nature, society, culture and people;
- A view of, and ideals about, occupational therapy;
- Practical knowledge of how to work with clients;
- Interest in the people we work with and in occupational therapy.

The therapist draws on these four areas of knowledge to build an understanding of the client’s life-world and to decide on the best way of working with the client.

The knowledge base of occupational therapy has expanded rapidly since the 1950s and now encompasses concepts, descriptive or explanatory models and applied theories. Occupational therapy students are exposed to theory during pre-registration education, including theories developed within occupational therapy, biomedicine, sociology, psychology and ergonomics. Most practitioners are exposed to new ideas and theories throughout their working lives, especially during times of rapid scientific discovery and change.

In order to be able to use theory effectively, the therapist has to be able to integrate explicit knowledge with practice. This involves: being able to identify dysfunction and function; understanding how people move between these two states; being able to predict how occupational therapy can influence that movement; recognising when interventions are not working, and finding more effective ways of intervening. The success of an intervention depends not only on the breadth and depth of the therapist’s knowledge but also on the quality of her understanding.

A good technologist usually specialises in a particular field, learns and keeps up to date with theory and practice in that area and even, perhaps, engages in research or theory development. Some technologists take further academic courses, either in occupational therapy or in other disciplines such as psychology or sociology. The technologist defines her practice by the theories that she uses, for example, ‘I use a cognitive-behavioural approach’ or ‘My work is based on the Canadian model of occupational performance.’

Skilled occupational therapy intervention is grounded in technical excellence and a sound understanding of the uses of theory, but not all expert occupational therapists are technicians or technologists. The American anthropologist, Cheryl Mattingly, wrote that the application of theory is a necessary condition for effective practice but is not sufficient in itself: ‘One cannot do without such a ground-
ing, but it, alone, will not yield good clinical interventions; because theoretical
reasoning differs from clinical reasoning’ (Mattingly, 1991, p. 980).

Mattingly went on to explain that theories are concerned with what can be
reliably predicted to hold true across the majority of cases. However, the occupa-
tional therapist is not just concerned with impairment, or with discrete problems
of function, but with how a health condition impacts on all aspects of a person’s
life, with the client’s illness experience. Some practitioners accept that the out-
comes of working with people in the context of their daily lives can never be
entirely predictable; these therapists are able to draw on a range of theories and
a store of experiential knowledge in order to find a way through complex situa-
tions. The practitioner who takes her practical skills and knowledge for granted
and puts clinical reasoning in the foreground is the thinker.

The thinker

A thinker is ‘a person who has highly developed powers of thought’ (Shorter Oxford
English Dictionary, 2002). Thinking means using the mind, exercising it in a
positive, active way. It includes such mental actions as applying rules, choosing,
conceptualising, evaluating, judging, justifying, knowing, perceiving and under-
standing. These are not exclusively professional actions but are the types of think-
ing used by all people as they go about their daily lives.

Thinking skills and strategies enable people to survive and to meet their needs
within an increasingly complex and constantly changing world. Modern society
is described as being characterised by ‘uncertainty, complexity, ambivalence and
disorder, a growing distrust of social institutions and traditional authorities and
an increasing awareness of the threats inherent in everyday life’ (Lupton, 1999,
pp. 11–12). In complex, threatening situations, people have to try to understand
what is going on and work out the best ways of coping, rather than responding
instinctively or habitually to circumstances: thinking has become a necessary
skill for human survival.

The practice of occupational therapy is not independent of its social context
but is subject to the same pressures and predicaments that abound in daily life.
Schön (1983, p. 14) claimed that ‘complexity, uncertainty, instability, uniqueness,
and value conflicts . . . are increasingly perceived as central to the world of profes-
sional practice’. This means that thinking has to be an integral part of being a
professional: professional practice is not just about doing things but is about doing
things thoughtfully (Nixon and Creek, 2006).

The occupational therapist has to be able to process a range of information if
she is to select the most appropriate course of action with an individual client,
within a specific treatment context, in order to achieve the best possible outcome.
She has to be aware of, and take account of (Creek, 2003):
- Her own capabilities and limitations. For example, the therapist’s age and gender will influence how her clients react to her and what she can expect to do with them.

- The elements that the client brings to the therapeutic encounter. These include his personal history and life experience, his language and culture, his thoughts, beliefs, values and aspirations, his relationships and occupations, and his needs, problems and goals.

- A multiplicity of contextual factors, such as the social environment, the setting where the therapist and client are meeting and the policy context.

In order to deal with all this information, and to incorporate it into the decision-making process, the therapist has to be able to think quickly and flexibly, using a variety of styles of thinking.

A study of how occupational therapists think in practice, commissioned in the 1980s by the American Occupational Therapy Association and the American Occupational Therapy Foundation (Mattingly and Gillette, 1991), introduced the idea of the therapist with a three-track mind. The tracks are three distinctly different ways of thinking in practice, depending on the nature of the problem being addressed and the purpose of reasoning. They are:

- **Procedural reasoning:** This is used when thinking about the disease or disability and deciding which activity to use in order to remediate the client’s functional performance problems. The experienced therapist generates and tests alternative hypotheses, actively seeking and interpreting patterns of cues in order to select the most appropriate treatment medium. However, the less experienced therapist is more likely to seek what she perceives as the right answer, rather than considering multiple possibilities.

- **Interactive reasoning:** This is used during face-to-face encounters, when the therapist is trying to understand the client as an individual – what he sees as his problems, how he feels about treatment, what his likes and dislikes are and what his aspirations are. The aim is to understand the experience of illness or disability from the client’s point of view – the illness perspective. This allows the therapist to match treatment aims and strategies accurately to the individual and to adjust them as the intervention progresses.

- **Conditional reasoning:** This form of reasoning places the client within his wider context. The therapist thinks about the whole experience of the client and his family, before and after the illness or accident, the social and physical contexts in which they live and the meanings that the illness or disability has for them. She thinks about alternative outcomes and possible ways in which the illness experience might change or be changed. Most importantly, the
therapist involves the client fully in the construction of possible outcomes. This type of reasoning is called conditional because ‘a change in the [patient’s] present condition was conditional on the therapist’s and the patient’s participation in effective therapy. This condition was dependent . . . on building a shared image of the person’s future self’ (Fleming, 1991, p. 1012).

Subsequent work by Sinclair (see Chapter 8) explored further the complex and multilayered nature of thinking in occupational therapy. The Sinclair Matrix of Clinical Reasoning incorporates five distinct types of reasoning:

- **Evidence discovery** includes problem sensing, problem formulation and problem definition.
- **Theory application** is theorising in practice. This is a process of thinking about what we are doing, in collaboration with others, so that we reach a shared understanding of goals and means (Nixon and Creek, 2006).
- **Decision making** includes the three types of reasoning described by Mattingly and Fleming as they are used to evaluate, plan, set priorities, predict and determine the best treatment approach.
- **Judgement** includes reflection on practice leading to recognition of divergent views and of one’s own biases.
- **Ethics** includes recognition of ethical issues, sensitivity to different views, and honesty in facing personal biases.

Mattingly and Fleming (1994), in the American clinical reasoning study, found that the way the therapist uses each type of thinking is different depending on her experience. However, the experienced therapist is able to move rapidly and smoothly from one form of thinking to another:

Reasoning styles changed as the therapist’s attention was drawn from the clinical condition to another feature of the problem, and to how the person feels about the problem. Therapists could process or analyze different aspects of the problem almost simultaneously, using different thinking styles; and they did not ‘lose track of’ their thoughts about aspects of a problem as those components were temporarily shifted to the background while another aspect was brought into the foreground.

(Fleming, 1994, pp. 120–121)

The thinking therapist finds it difficult to say what she does, or to define her role, because practice is person-centred, that is, the intervention is directed by the client’s needs and goals. The therapist does not know what techniques or theories
she will use until the intervention is negotiated with the client and relevant others. She does not see herself as an expert in the client’s life but recognises that the client is the expert in his own life.

The therapist who practises in a person-centred way is working in partnership with the client. Her role and approach are not predetermined but are negotiated with the client as part of the process of therapy. This means that the therapist has to pay close attention to what the client is saying, without trying to fit him into a theoretical framework that might have more to do with her own needs than with the reality of his life (Smith, 2006). In the person-centred approach, theories are tools that can be used or discarded, depending on how useful they are to the client, rather than being seen as frameworks that structure practice.

In person-centred practice, instead of relying on pre-existing theories to guide practice, the therapist uses ‘a range of mental strategies and high level cognitive processes . . . to reach a decision about the best course of action’ (Creek, 2003, p. 39). Decision making, in the therapeutic context, is ‘a deliberative process whereby we move backwards and forwards between consideration of ends and means in order to decide upon the best possible course of action’ (Nixon and Creek, 2006, p. 78). Crucially, this deliberation is done in partnership with the client: thinking can be seen as an ongoing dialogue between the therapist and client.

The technician, the technologist and the thinker are names given to three facets of the occupational therapy practitioner. They indicate approaches to different types of problem encountered within the practice of occupational therapy but they do not denote a level of skill or expertise. The expert practitioner may be highly skilled in using practical techniques, in applying theory, in thinking or in all three. In the next section, the nature of expert practice is explored.

The development of expertise

In the 1970s, the United Stated Air Force commissioned research into how pilots learn their complex, high-level skills. A mathematician and a philosopher, Dreyfus and Dreyfus (1980, in Benner, 1982), studied how chess players and pilots learn their skills and produced the Dreyfus model of skill acquisition, which describes five levels of proficiency through which the learner passes during the learning process:

1. **Novice**: The novice, or beginner, has little or no experience with the situations in which he has to work, therefore he depends on what he has been taught to guide his actions. The novice is not able to use his discretion in making judgements but has to follow context-free rules. An example of this kind of rule is a guideline taken from an American occupational therapy textbook:
An effective way to gather information about a client’s problem is to ask open-ended questions. Open-ended questions are structured so that one cannot answer them with a simple yes or no. In contrast, closed questions are so structured that one can answer only yes or no. Open-ended questions result in answers that are richer than yes or no.

(Lewin and Reed, 1998, p. 52)

The novice practitioner who has learned this rule will follow it with all clients in all situations without taking account of individual differences.

2. **Advanced beginner**: After some experience, the practitioner has been in enough real practice situations to recognise salient aspects, or patterns, and can demonstrate marginally acceptable performance. The American nurse theorist, Benner (1986, p. 404), said that ‘while aspects may be made explicit, they cannot be made completely objective . . . Aspect recognition is dependent on prior experience.’ This means that learning to recognise patterns is an important part of the learning process for beginners and advanced beginners.

3. **Competent**: Competency typically develops when the practitioner begins to see his actions in terms of long-term goals. These goals determine which aspects of the situation are considered most important and which can be ignored. The competent practitioner is organised and efficient and has a sense of being able to cope. Most health and social care institutions expect their staff to abide by rules, protocols and standardised procedures, so the competent practitioner works comfortably within these settings.

4. **Proficient**: The proficient practitioner perceives situations as wholes rather than aspects or patterns. The current situation is compared with a range of similar experiences that the practitioner has had, so that anything unusual is immediately noticed and dealt with. Proficient performers are able to respond flexibly to changes in the situation.

5. **Expert**: At this level the practitioner no longer relies on rules or guidelines but is able to draw on a broad range of experience to sum up the situation intuitively and focus on the problem. It is difficult to describe expert practice in words because it depends on embodied knowledge that allows the practitioner to respond to changes in the environment without conscious thought. This kind of knowledge can only be gained from practical experience. Mattingly (1991, p. 979), wrote that ‘Words always fall short of practice’ and that ‘The gap between what we can say and what we know may . . . grow as we gain professional expertise.’

Expertise in a complex skill can only be learned in practice and developed with experience. The British occupational therapist, Jenkins, in her study of how
occupational therapists learn in practice, emphasised the importance of having time to learn alongside more experienced professionals (Jenkins and Brotherton, 1995). She described occupational therapy as being located within a community of practice. The essence of community is communication and interaction: ‘interaction with fellow practitioners in the job, on the job and about the job [extending to] communicating with external agencies’ (Jenkins and Brotherton, 1995, p. 283).

The learner, or novice therapist, starts out by being peripherally involved in the community, watching and listening to more experienced practitioners in action. Through such peripheral participation (Lave and Wenger, 1989, in Jenkins and Brotherton, 1995), the novice learns what happens in context and begins to make sense of what she sees and hears. Crucially, she learns not only how to do the job but how to do it in context. The end point of such learning is full participation in the community of practice.

The student

Occupational therapy students are novice practitioners, in the language of the Dreyfus and Dreyfus study (1980, in Benner, 1982). At the beginning of their educational programme, they have little or no experience of practice and depend on what they are taught at university to guide their actions while on practice placements.

Mastery of some basic technical skills is necessary for the student to be able to move from observing practice to trying out techniques, under supervision, in the treatment context. The student occupational therapist embarking on a first practice placement is expected to learn by observing what goes on. By the time of the next practice placement, she needs to know how to carry out core professional tasks within that setting so that she can take the first steps towards becoming a practitioner. By gaining experience in a range of practice settings, the student learns core skills and techniques for different areas of occupational therapy practice. These include transferable skills, such as communication, activity analysis and functional assessment, and specific skills for working with various health conditions.

The student also starts to learn how to apply theory in practice by observing her supervisor on the first practice placement and asking for explanations of why things are done in the way they are. By the second placement, she should be able to follow rules and guidelines that she has been taught at university, learned from books or picked up from her observations on the first placement.

Sinclair (Chapter 8) identified the thinking skills of the novice occupational therapy practitioner as limited. The student does not know what information to seek when meeting a client for the first time, and she is not able to
identify which aspects of the situation to ignore and which to pay attention to. She is unable to modify what she has learned in the academic setting to suit the context of the fieldwork placement, so her application of theory is inflexible. She is slow to formulate problems and to decide what to do, and she has difficulty dealing with unfamiliar situations.

Throughout two, three or four years of study and practice placement experience, the student occupational therapist develops her practical skills, theory base and thinking skills. At the time of graduation, the new practitioner should, at the least, have reached the level of advanced beginner.

**The new practitioner**

The newly qualified occupational therapist, in order to be judged fit to practise, must be competent in a number of practical skills that are specified by professional bodies, such as the World Federation of Occupational Therapists (2002), and regulatory bodies, such as the Health Professions Council (2003). She must, for example, be able to: use activity analysis and synthesis to realise the therapeutic potential of occupation; adapt and apply the occupational therapy process in collaboration with individuals or populations, and work towards making environments accessible and adaptable (European Network of Occupational Therapists in Higher Education, n.d.).

The beginning therapist is expected to have a range of knowledge that can be used to guide practice until she has enough experience to pick out the salient features of a situation and make decisions about what is important in these circumstances. For example, the new graduate is expected to ‘know how professional principles are expressed and translated into action through a number of different assessment, treatment and management approaches and how to select or modify approaches to meet the needs of an individual’ (Health Professions Council, 2003, p. 15).

Sinclair (Chapter 8) described how the beginner is able to incorporate some contextual information into her rule-based thinking, because she has had a range of practice experience during placements. She still follows procedures but is able to recognise some patterns. However, she cannot recognise what features of a situation are important or determine priorities for action. Her practice is still slow and awkward.

As described above, some therapists choose to develop one aspect of their practice to a level of expertise while they remain merely competent in other aspects. The expert technician advances and maintains expertise in practical skills; the expert technologist understands and keeps up to date with the use of theory to direct practice; the expert thinker develops her ability to think flexibly and fluently about the situations she encounters, using different types of thinking
to deal with different types of problem. But the expert occupational therapist must have expertise in all three approaches because practical skills, theory and thinking are all essential elements of effective occupational therapy practice.

The expert occupational therapist

Skilled observers of occupational therapy have described the complex, dynamic nature of occupational therapy practice and stressed the range of knowledge and skills that are required for practitioners to fulfil their demanding professional role.

In the 1970s, a sociologist, Alaszewski, undertook a comparative study of three health care professions. He observed that some professions are ‘technique-oriented’, in that they define their area of practice and competence in terms of a technique: for example, radiography is concerned only with patients who require that technique (Alaszewski, 1979, p. 432). In contrast, occupational therapy is ‘patient-oriented’, in that it is concerned with ‘the social effects of disease’ and with intervening ‘in the social and physical environment to adjust it to the individual’ (p. 432). This orientation means that occupational therapy is not limited in its application but can be of benefit to ‘an expanding range of client groups’ (p. 437).

A physician, Engelhardt, wrote in the 1980s that occupational therapists take different roles and move between them depending on the needs of the patient. He identified occupational therapists as both technologists, applying scientific theories to address treatment problems, and custodians of meaning, ‘conveying complex services of care and guidance’ (Engelhardt, 1983, p. 141).

The role of technologist requires that occupational therapists have:

a theoretical base grounded in the internal, organic, and psychic conditions of the organisms. That is, occupational therapists function as scientist-technologists, appealing to muscular skeletal status, sensory motor and nervous system function, and intrapsychic states to aid individuals to regain and maintain as much independent function as possible.

(Engelhardt, 1983, p. 141)

However, to be human is to look for meaning in events, and the people who use health care services are not only seeking treatment but also need the therapist to help them explore what it means to have a health condition. They ‘want both a scientific account [of their condition] and an account in terms of their functioning in everyday life’ (Engelhardt, 1983, p. 141). To satisfy this need, occupational therapists have to ‘offer models of therapy which take into account not only
physical capacities, but the virtues of human adaptation in recreation and in physical and mental activities generally’ (p. 144). Engelhardt described this as a sacerdotal role ‘in which [occupational therapists] aid individuals in orienting themselves within the changing circumstances of aging, illness and disability’ (p. 143).

The anthropologist, Mattingly, also observed that occupational therapists work with more than just functional problems, ‘the body as machine’: they also address ‘problems that go far beyond the physical body, encompassing social, cultural, and psychological issues that concern the meaning of illness or injury to a person’s life’ (Mattingly, 1994, p. 37). She described occupational therapy as a ‘two-body practice’ that encompasses both a disease perspective, which focuses on problem identification and treatment, and an illness experience perspective, which is concerned with the ways that disease affects a person’s life (p. 37). The occupational therapist has to be able to perceive and understand the client’s problems and needs from both these perspectives.

Mattingly observed that an occupational therapist can ‘interweave interventions that address both the disease and the illness experience into the same treatment activity’, shifting between two distinct approaches with the same patient within the same session (Mattingly, 1994, p. 38). The expert therapist is able to move easily and naturally from one approach to the other, using her clinical reasoning skills to synthesise and integrate these two types of practice.

The clinical reasoning study by Mattingly and Fleming (1994) and the Dreyfus and Dreyfus study of the acquisition and development of complex skills both describe highly skilled practice that does not just focus on a discrete problem but is responsive to the environment and ambient conditions. Both put an emphasis on the thinking skills and processes of the practitioner as she applies her practical skills to the situation. Both conceptualise the expert practitioner as one who can think in a variety of ways, who is flexible in changing her thinking to suit what is being thought about and who thinks so quickly that her decisions appear to be intuitive rather than the result of cognitive processes.

Two Danish occupational therapists, Fortmeier and Thanning, developed a model of the occupational therapy process that acknowledges the complexity of practice and offers a way of understanding how the therapist manages to keep the different strands in place over time (Fortmeier and Thanning, 2002). The model describes five tracks that represent aspects of the occupational therapist’s intervention:

- **The motivation track**: this is about developing and maintaining the patient’s motivation for treatment and seeking his active engagement in the process. It requires the therapist to be sensitive and responsive to the patient’s changing needs.
• **The communication track**: this is about the quality of the therapeutic relationship that is necessary for an intervention to succeed. It is based on mutual respect and partnership.

• **The skills and functions track**: this concerns the patient’s functional problems and the resources of the therapist for dealing with them. These resources include the therapist’s practical skills and clinical reasoning.

• **The activity track**: this track is about how the therapist plans programmes of intervention and selects activities that will both meet therapeutic goals and have meaning and value for the patient.

• **The combination track**: this combines the four other tracks of the occupational therapy process with the therapist’s reflections on her own actions and on the context of the intervention. It is the track in which all the elements of the situation are integrated to produce a relevant, co-ordinated and effective intervention.

Throughout the intervention process, these five tracks interact as the therapist develops, with the patient, an appropriate and effective approach to addressing the complex and dynamic pattern of illness, illness experience and adaptation that is the domain of concern of occupational therapy.

**Summary and conclusion**

This chapter explored the nature of occupational therapy as an individualised, contextually specific and complex intervention that requires of the practitioner a wide range of skills. It considered three ways in which occupational therapy practitioners approach their work:

• the technician, who focuses on using practical skills to solve the problems faced by her clients;
• the technologist, whose interventions are guided by theories, models and frames of reference, and
• the thinker, who uses a range of thinking skills to process complex information in order to be responsive to changing needs and circumstances.

The nature of professional expertise was discussed, drawing on studies of how people develop high-level practical skills. Some consideration was given to how occupational therapists develop expertise as technicians, technologists and thinkers.
The profession of occupational therapy needs people who have good practical skills, those who understand the value of theory in explaining and guiding practice and those who can manage the complexity of working in partnership with their clients to rebuild lives that are limited by illness or disability. The therapist may become an expert in any or all of these approaches, but true expertise in occupational therapy practice can only be achieved when they are all integrated. The expert occupational therapist is a thinker, a knower and a doer.

References

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