Feature Article

A longitudinal study on the transformation of 15 occupational therapist students’ paradigms into occupational therapists’ paradigms

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Background and Aim: This study describes the transformation of 15 occupational therapist students’ paradigms into occupational therapists’ paradigms according to Törnebohm’s theory of paradigms over a period of 6 years. This research particularly considers the paradigm components world view and field of action view in Törnebohm’s sense.

Method: Qualitative data were collected using essay questions on three occasions: first week and last semester at the Occupational Therapy Programme at the School of Health Sciences, Jönköping, Sweden, and after 3 years of occupational therapy practice. A content analysis of the collected materials was performed.


KEY WORDS essays, longitudinal study, professionalisation, Törnebohm’s theory of paradigms.

Introduction

Learning how to be an occupational therapist implies several dimensions of knowledge processing. Adapting to the professional paradigm is one such dimension of central significance for developing confidence in the professional role. Professional skills involve the whole person, including attitudes as well as intellect (Smith-Randolph, 1993). A main objective of occupational therapy education is to mediate knowledge and practical attainments to facilitate students’ development of confident professional roles. This process involves the development of occupational therapist paradigms. These paradigms will continue to evolve as occupational therapists acquire practical work experience and additional theoretical knowledge.

It is of considerable interest to study the way occupational therapist paradigms evolve and change during education and practical occupational therapy work. Occupational therapists as a professional collective are comparatively recently established within the health-care system, and therefore, the developing of professional paradigms, the definition and demarcation of a specific area of expertise and the elaboration of knowledge claims are still underway. Increased knowledge of these processes is urgent from the point of view of intraprofessional interests as well as from the point of view of the division of work within the health-care system in a wider sense.

In this study, the interest was directed to the transformation of occupational therapist paradigms among 15 occupational therapy students at the Occupational Therapy Programme at the University College of Health Sciences, Jönköping, Sweden. With a point of departure in Törnebohm’s theory of paradigms (1987), we started the exploration in the autumn of 1995, by investigating newly enrolled occupational therapy students’ reflections on their future profession during their introductory week (Björklund, 1999). We continued the exploration at the end of their last year at the same programme (spring 1998) and after they had experienced 3 years of occupational therapy practice (autumn 2001).

Törnebohm’s theory of paradigms is different from other theories, for instance Kuhn’s (1996), in a crucial respect. According to Törnebohm, paradigms are personal and not collective, but affinities amongst a group of personal paradigms could be regarded as a potential ideology for that arena of action (Björklund, 2000). Törnebohm’s theoretical framework of paradigms, when applied to occupational therapists,
embraces four mutually influencing components: \( \text{WV} \), world view; \( \text{I} \), interests; \( \text{FV} \), field of action view; and \( \text{C} \), competence (Törnebohm, 1987, 1991, 1997).

According to Törnebohm (1985), the components within paradigms are interrelated in the way that interests and competence strengthen each other, and the field of action view and the world view partially determine each other. The components can be studied separately; however, in this study, we have chosen to focus on the field of action view and on the world view components. These two components are the ones that most distinctly elucidate what is the core of a professional occupational therapist identity as perceived by the individual professional. Some previous studies (Björklund, 1988, 1994, 1995) also pointed towards affinities within the paradigm components world view and field of action view.

The aim of the study thus was to characterise the transformation of 15 occupational therapist students’ paradigms into occupational therapists’ paradigms, especially regarding world view and field of action view, during a period of 6 years.

Methods

Following the suggestions by Törnebohm (1985) for inquiring into paradigmatic matters, qualitative data were collected using open-ended essay questions at three occasions: first week (autumn 1995) and last semester (spring 1998) at the Occupational Therapy Educational Programme and after 3 years of occupational therapy practice (autumn 2001). With reference to the two paradigm components \( \text{WV} \) and \( \text{FV} \) (Törnebohm, 1994), a content analysis of the data was carried out qualitatively in relation to three themes and the associated categories from Björklund (1999).

Informants

1995: Of the 40 students at the first week of their educational programme, only 32 students elected to complete the essay questions. One student left the program, one student moved to another educational program and six students did not want to participate for unknown reasons.

1998: Twenty-one students remained from the group who answered the questions in 1995 (\( n = 32 \)). Nineteen of the 21 answered the essay questions in the last semester of their educational programme. Two students did not want to participate for unknown reasons.

2001: Fifteen occupational therapists (former students) from the group who answered the questions in 1998 (\( n = 19 \)) answered the essay questions after 3 years of occupational therapy practice. Four occupational therapists did not participate, and of these, two therapists specified high work load together with personal reasons, one had left the profession for a former occupation and one did not want to participate for unknown reasons.

1995–1998–2001: Fifteen persons answered the essay questions on three occasions, 13 women and two men. On the first occasion of data collection, the participants were between 19 and 37 years of age, with a mean age of 22.5 years.

Since no sensitive data or personal records were set up, the Committee of Research Ethics did not have to approve the study, but the study is conducted in accordance with the recommendations of the Research Council of Humanistic and Social Science (HSFR, 1990).

Data collection

1995 and 1998: After a short introduction by the first author in a class setting, the informants were asked to participate in the study. Each informant received a letter with information about the study, together with 10 questions. Eight of these questions were the same at both occasions (Appendix 1). (There were also two additional questions unique for each occasion pertaining to expectations from and evaluation of the programme. The answers to these questions were not analysed in this study.) They also received sheets of paper, one for each question, to use when writing down their answers. Each student was given a random code number from 1 to 100 to ensure confidentiality. All responses were to be returned within 1 week. Each contribution was sorted out in relation to questions 1–8. The information was typed out and marked in relation to the number of essay question and informant’s code. It comprised 28 pages with two persons who did not answer question 4 in 1995 and 40 pages, with one person who did not answer question 2 in 1998.

2001: The informants were contacted once again by letter in the autumn of 2001. Their current addresses were obtained from the tax authorities. The ones who agreed to answer the questions received a covering letter, the eight questions and eight sheets of paper. They were also requested to give their answers within a period of 3 weeks. Their answers were arranged and processed in the same way as in 1995 and 1998. The material comprised 44 pages, with two internal drop-outs: one at question 1 and one at question 3.

Data analysis

A content analysis of the collected data was performed. The starting point of our analysis was the structure of paradigms found by Björklund (1999),
in her study of the occupational therapy students’ paradigms in 1995 (Fig. 1). This structure was the foundation of our analysis and made possible the 1995–1998–2001 comparison. To accomplish a detailed and informative description of paradigm transformations, we have used a qualitative analytical approach in a broad sense (Patton, 2004).

The data was thus sorted out into three themes belonging to the paradigm components world view (WV) and field of action view (FV), with the associated categories:


The two authors separately read the data from the three years several times and coded the answers according to the structure outlined above. Then they compared and discussed their findings until mutual agreement was reached about the major similarities and differences. Changes over time for each category, indicating paradigmatic transformations, were then described and characterised. Finally, an overall characterisation of the data from 1995, 1998 and 2001 was made regarding world view and field of action view.

Findings

The presentation here follows the structure of themes and categories presented above. Each category description begins with a presentation of what is common to the informants’ notions at all three points of time, 1995–1998–2001. It continues with the differences between the informants’ notions on the different occasions and ends up in, what is here called, a presentation of the transformation of paradigms for each category. The ‘transformation statements’ are intended as short, summarising characterisations of the main paradigmatic changes for each category as perceived by the authors. The quotations from informants are marked with the informant’s code number and the year of data collection; for instance, 24: 01, which means informant number 24 in the year of 2001. The quotations are chosen as illustrative examples and are supplied to substantiate the authors’ interpretations.

Notions of some concepts fundamental to occupational therapy (world view)

This theme involves three fundamental concepts that are involved in occupational therapy practice: health, activity and self-determination.

Health

At all three points of time, 1995–1998–2001, a subjective determination of health was the focus in the informants’ essays, that is, if a person is healthy or not, is decided by the individual him/herself. The individual’s determination of health was linked to a feeling and an opportunity for action.

To be in good health is to feel satisfaction and appreciate the life you are living and what you accomplish. To be in good health is my own internal ideas of how I feel, function and nothing external measured by someone else. (75:01)

In 1998, the respondents often expressed an awareness of the importance of certain prerequisites to the experience of health like leisure interests, good family...
relations and having enough money. This awareness was additionally accentuated in 2001 when respondents stated that the experience of health depends on environmental circumstances in a more general way.

To be in good health does not necessarily mean the absence of illness, but physical, psychological and social well-being. To have enough resources to fulfil one’s basic needs and to realise one’s vital life goals. (13:01)

Transformations: A growing insight into the environmental influence on the individual’s experience of health.

Activity

At all points of time, the informants pointed out two dimensions of activity, that is, activity is a goal in itself, but activity is also a tool, something one uses to reach other goals. In the essays of 1995, the focus was more on activity as a tool to experience certain feelings.

Activity is every physical and psychological ‘movement’ or work. A tool within occupational therapy aiming to enhance the patient’s health condition. Activity is probably essential for people to feel good and to experience psychological and physical balance. (27:95)

This could be compared to the data from 1998 and 2001, where the characteristics of activity were more often specified as having purpose as well as meaning.

When I wrote that activity ought to have a purpose, I mean that when a stroke patient has to sit and wipe a table with a towel to get his shoulder moving forward, this is not an activity because it has no meaning. On the other hand if the patient wipes the table after dinner, the wiping is an activity because the meaning is to get the table clean. (86:98)

Activity is certainly our domain. The activity can be used for many different reasons. There should be meaning and purpose behind, with an activity, if it is occupational therapy, it should be well-defined. (12:01)

At all three points of time the context is mentioned as a qualifier of activity. In 1995, one of the purposes of activity was specified as interaction with the environment. In 1998, the context was represented by the characteristic of participation, and in 2001, the context of activity was articulated as sociocultural, shaping identity and building life.

Human activity is part of a person’s identity. Activity is necessary for our psychological and physical health. A person can influence her/his health through activity. Family, friends, culture and society influence which activities one chooses, and how they are experienced by the person. A person’s pattern of activities ought to be seen in a context with regard to the sociocultural environment. (13:01)

Transformations: The meaning of ‘activity’ as lived experience in a context became more accentuated.

Self-determination

Internal human resources often displayed as will-power and motivation, dominated the informants’ apprehensions of prerequisites of self-determination at all points of time. External human and non-human resources are contributing to the experience of self-determination according to the informants’ essays. In the data of 1998, many informants noted that attitudes in society are important in influencing self-determination.

To influence one’s situation one has to be willing to come back. I think that a person always strives to be as well as possible after trauma or injury. But this calls for a supportive environment. The society’s view on illness plays a great part. In certain countries they look down at sick and handicapped people. There ought to be a collective contribution if the person is to feel motivation and be willing to change and influence her/his situation. (79:98)

In 2001, they also often expressed the importance of accepting help and delegating duties for the experience of self-determination.

In many cases I think you really can if you really want to. Maybe not to the same extent as earlier (before illness or trauma) but in another way. One has to have a positive spirit managing difficulties, otherwise one will not succeed. One has to accept help from others, maybe delegate housework to others, to be able to do something really enjoyable. (24:01)

In the essays of 2001, the informants also accentuated freedom from illness, access to medical treatment and support from society as important impact factors for self-determination.

The healthy person has good opportunities to influence her/his situation. Often it is only her-/himself who can influence it. People around can only motivate, entice and lead. On the other hand a person who is really sick has considerable difficulties to influence her/his situation. (19:01)
Then there are life situations where the person mainly has to rely on medical treatment. In my present work situation I often experience how persons can be dependent on different authorities and laws when they are stricken with traumas of different kinds. (27:01)

**Transformation:** The environmental influences on self-determination become more emphasised.

### Notions of the ‘setting’ of occupational therapy reality (world view)

Practice area, patients, occupational therapists and occupational therapy work are four integral parts of occupational therapy reality.

#### Practice areas

The practice areas of occupational therapy are represented by three main categories according to all points of time: localities where occupational therapy is implemented, specialities often linked to diagnosis, and the health-care continuum. In 1995, the informants gave examples from the health-care continuum in a more general way like prevention–habilitation–rehabilitation–caring, and in the essays from 1998 to 2001, the end points of the health-care continuum were articulated like acute/hospital care and primary care. The content of the category specialities became more substantial and refined during the six year period. In 1995 only specialities in relation to diagnosis were mentioned, for example rheumatology, geriatrics and psychiatry. In 1998, special types of rehabilitation were exemplified: work/medical/home/children rehabilitation, and in 2001, ergonomics and keep-fit measures were accounted for as specialities of occupational therapy.

**Transformation:** Increasing awareness of the variety of occupational therapy characteristics in relation to the situation in the rehabilitation chain.

#### Patients

Two qualifiers for being occupational therapy patients were discerned at all points of time: namely causes and consequences.

I am mostly interested in working with people who are injured from work or trauma. (11:95)

The doctor sees symptoms, while the occupational therapist sees symptoms and their consequences. Especially consequences of disabilities are particular to occupational therapists, I think. (05:98)

Occupational therapists work in a problem orientated way to solve or reduce problems caused by trauma or illness. Occupational therapists treat consequences of trauma or illness to increase the activity ability within the areas of personal care, work/education, housing or leisure. (13:01)

Causes were in most cases related to diagnosis and were exemplified as illnesses and/or injuries. Consequences were represented by functional problems on different levels of occupational performance, that is, the body–activity–participation level. Occupational therapy patients could be characterised as different age groups according to the essays of 1995–1998, which was not the case in 2001.

I prefer to work with younger persons who have been struck with something which makes them consult an occupational therapist. What interests me the least is to work with the elderly. This is probably a great part of occupational therapy but is something I find hard to do. (28:95)

What interests me the least is psychiatry and to work with the elderly only. I do not like meaningless tests as for example the peg-board. Occupational therapy should have meaning to the patient. What interests me the most is to work with children or mentally retarded persons. (76:98)

**Transformation:** More of focusing on the consequences of trauma and disease, than on the cause (diagnosis), for the person’s occupational performance in daily life.

### Occupational therapists

In the essays of 1995, occupational therapists were mainly described in terms of personal attributes, like qualities and attitudes, with regard to patients, work and environment. In 1998–2001, the descriptions of occupational therapists involved two main categories, roles in practice and the therapeutic encounter. In the essays from 1998, the informants often considered an occupational therapist, amongst other things, to fill the role of being a theory transmitter, which is a dimension not mentioned at all in the essays from 1995 or 2001.

To get an insight into the different theoretical models is really fun, especially when it comes to recommending a certain type of treatment to the patient. I hope this will work in reality also, i.e. not only what you have learnt in school. (79:98)

In 2001, specific information and instruction measures were accounted for and regarded as belonging to a consultative role of an occupational therapist.

Furthermore the occupational therapist has an important role in supervising personnel, relatives in transfer techniques and technical devices, when the
user is unable to take an active part. We are responsible for training nursing staff or caring personnel. One works like a consultant a lot. 

When it comes to the therapeutic encounter, the main characteristics in 1998 as well as in 2001 involved the shaping of a professional relationship characterised by humbleness, listening, motivating, and above all, engagement.

We occupational therapists always succeed to find some resource or something positive in the people we meet at work. Furthermore, I think that we occupational therapists are deeply engaged in what we do, grip things; work a lot with quality development. We are very energetic; do not give up easily.

**Transformation:** The apprehensions of occupational therapists have transformed from descriptions of being an occupational therapist to acting as one.

**Occupational therapy work**

Occupational therapy work was delineated by describing positive and less positive features at all points of time. The positive features in 1995 were characterised as a meaningful practice and as a psychosocial orientation. In the data from 1998 to 2001, a positive feature of occupational therapy was represented by the holistic view of individuals interacting with their environment.

We try to look a step further. What happens when the patient arrives at home after the hospital stay? How does it work? What has the patient been doing before? How can we reach that again? Other personnel often see only the part which causes the patient to come to the hospital. We are trying to see to the whole picture. We work with the patient’s goals and aspirations. We take everyday life into the hospital. What impact has the trauma/illness on the person’s everyday life?

In 1998, the informants accentuated the multiplicity of occupational therapy work as a positive feature described as a continuum from creative work to routine work, but also exposed less positive features of this multiplicity, like making professional demarcations and claiming professional identity. These less positive features were further accentuated in the essays of 2001, as manifested in a lack of respect and a difficulty to gain a hearing from team members.

The telephone is ringing and we are running. Sometimes it feels like we are the ‘sink’, taking care of everything nobody else wants to take care of.

I had hard times working at a nursing home where other personnel, and sometimes myself, did not really know what I was there for. The physiotherapist often took over definitively; everybody else knew what they were doing. It was hard to sense one’s importance.

**Transformation:** The multiplicity of occupational therapy, first viewed as a positive feature of occupational therapy, is increasingly also viewed as a less positive feature when it comes to professionalisation.

**Notions of the operational reality of occupational therapy (field of action view)**

Four orientation strategies within occupational therapy practice constitute the third and last theme: goals, interventions, methods and tools.

**Goals**

Goals of occupational therapy were at all points of time mostly described as client-centred with a focus on two main orientations: feeling and action. In the essays of 1995, the feeling orientation primarily concerned quality of life and a changed life attitude. In the data from 1998, the informants emphasised life satisfaction and activity balance as important feeling factors, and in 2001, the feeling factors concerned independence regarding occupational performance, with an accentuation of participation in society.

To see to that people do not give up after something has happened that changed their lives. To find devices, or another way of doing things, so they see that it is not impossible.

The occupational therapist with her/his holistic view can look upon the individual from a broad perspective where one strives for meaningfulness in life and life-satisfaction, but also a balance between work, leisure and rest. The person should be able to be socially and culturally participating in society. The person should be able to regain work, education or a meaningful home life and leisure. The person should be able to manage as independently as possible. To facilitate the person’s occupational performance.

In the essays of 1995–1998–2001, the action orientation was frequently related to a balance between the two concepts of independence and participation. In 1995, the action orientation was characterised as functioning on the body level, but also as an active life filled with everyday and leisure activities. In 1998, confident occupational performance was often in focus as an action orientated goal for occupational therapy, and in 2001, this was expressed as an active life with dignity.
The patient ought to manage her/his self-maintenance as independently as possible, and to have pleasant housing and job, which will also work practically. Everyone also has the right to meaningful leisure time. (4:95)

The patient should be independent in her/his daily activities (all of them or only one) and manage to perform the activities in a safe way. (05:98)

I would like to say that the most important thing is to regain a life as active and worthy as possible for the patient, by treatment and compensation for the patient’s disabilities. (27:01)

Transformation: A feeling and action orientation transformed from a personal perspective to a more societal perspective, related to the person’s lived experience of participation and activity.

Interventions
Occupational therapy interventions are at all points of time primarily focused on the individual and on the environment. In 1995, the informants described interventions in terms of starting points and realisation. Starting points were the individual’s abilities-needs-wishes, but also her/his life-situation, and a trusting relationship characterised by empathy according to the informants’ essays. Realisation was expressed in terms of examples related to both the individual and the environment.

I have apprehended an occupational therapist’s main work task as to see what a patient needs for her/his adaptation to the ‘usual’ life. She ought to supply different devices like wheel chairs, devices for putting on the stockings and pinchers if needed. She could teach both the patient and relatives how to use devices and do exercises. She can see to it that doorways are being widened, outer doors opened automatically, door steps taken away. Simply to make the environment adapted to disablement. (24:95)

The material from 1998 to 2001 was often focused on the occupational therapy process comprising data collection, goal setting, to plan/take measures, evaluation and journal documentation. In 2001, the informants accentuated the concept of enabling activities in the process step of planning/taking measures.

The main task is to create resources for a person in order to manage as much as possible the personal or other activities she/he wants to do her/himself. It is important to create opportunities for the person to live a life in accordance with her/his wishes as far as possible. It may also involve arousing the will of the person, relatives or the personnel. (14:01)

Transformation: From separate, mostly visible interventions to interventions structured in a process model, ending up in ‘enablement’ of activities by more embedded interventions in relation to the individual’s experiences of meaningfulness in life.

Methods
There were no descriptions of occupational therapy methods common to the three points of time. In 1995, the informants described strategies in relation to the individual, the physical environment and the human environment, often characterised as problem solving.

Together with the patient find out solutions; give exercises (rehabilitation, habilitation) for a patient who does not manage her/his everyday life-situation without help, as a result of trauma/illness or handicap, physically or psychologically. (27:95)

In 1998, the essays exposed three different and hierarchical methodological approaches in relation to an individual’s functional problems, namely: exercises, adaptation and/or compensation.

It can be about helping an individual, stricken with illness/trauma, to find out new ways of carrying out her/his activities. Sometimes it calls for devices as compensation, when we cannot help the patient by a different occupational performance or rebuild a function by exercises. (86:98)

In 2001, the informants’ essays reflected three categories of strategies in occupational therapy: creating prerequisites, stage setting and supplementary work. Creating prerequisites was represented by different ways of collecting data or instructing caring staff.

Investigation/mapping and measures in relation to the occupational therapy process. Additionally to use one’s knowledge and experiences. My experiences are that the means for mapping problems and resources in the patient are different tests and assessment instruments, observation in activity. Conversation/interview with the patient is an important means. This with the purpose of exploring the accordance of the patient’s and my apprehensions of problems and resources, including how the problems should be taken care of. (27:01)

Within municipality geriatric care it is often a matter of making the personnel understand that it is better in the long term perspective to let the person do things her/himself compared to choosing the easiest way of helping them. (14:01)

Stage setting concerned what occupational therapists do when they implement occupational therapy.
Helping the patient to overcome activity problems. If you cannot regain the occupational functions by exercises, maybe the activity can be carried out in a different way. If this is impossible devices or adaptation of the environment may be necessary. (86:01)

Supplementary work concerned what occupational therapists do for personal and professional development and comprised quality work, reading literature and development work.

Transformation: From unspecified problem solving, by way of a structural succession of methods for regaining the individual’s functions after illness/trauma, to the lived experience of occupational therapy as a whole.

Tools
In 1995, the informants primarily named the more visible tools of occupational therapy, like technical devices, exercise programs and crafts.

I feel I do not know so much about methods and devices (I hope I will learn this) but what I have seen the most is a lot of hobby activities like weaving and woodwork, and different exercise programs for different parts of the body. (14:95)

They framed other tools through descriptions, like everyday activities and the occupational therapist her/himself.

This is how I understand it. The occupational therapist helps people to have an everyday life as active as possible in spite of disability of some kind and to manage this they have to use all different tricks and devices available. (19:95)

But I think the most important thing is to give of one’s best and to engage oneself and be supportive, but the most important thing is to make demands on the patient for reaching results. (75:95)

The data from 1998 to 2001 comprised the same categories of tools for occupational therapy: activities, the social and physical environment and the occupational therapist her/himself.

The main work task of an occupational therapist is to, from the individual’s perspective, support her/him in getting a life which suits the individual. The everyday activities the individual wants to manage, so they function satisfactorily. The occupational therapist uses activities to achieve this. You also change the environment if needed to make things easier. What an occupational therapist does must accord with the individual; they must share the same goals. The occupational therapist collaborates with others in helping the individual in the best way. (12:98)

As a tool I have to use my knowledge of rehabilitation, but also my personal qualities. It is important to have good relations with all persons involved. It is a matter of having a sensitive ear and if possible also catch unspoken wishes. Another tool are the resources surrounding every person who receives care. It is fine of course, if there are resources like different kinds of material at the nursing ward, but for most people it is important to manage at home, in their own housing, and therefore it is essential to use what is there to support the person in being independent. I think more and more that home-rehabilitation gives the best results, even economically. (14:01)

Transformation: From being vaguely framed by the informants, the embedded tools of occupational therapy, like everyday activities and the occupational therapist her/himself, become clearly articulated. The importance of using the environment as a tool in occupational therapy becomes accentuated during the time period.

An overall characterisation of paradigmatic change
The transformation of occupational therapist paradigms in this study can be summarised according to the overall character of each of the three data sets as a ‘public’ view in 1995, a ‘theoretical’ view in 1998 and an ‘experiential/contextual’ view in 2001 (Fig. 2).

Discussion
Using Törnebohm’s individual–paradigm approach in exploring the professional transformation and development of occupational therapy students into occupational therapists proved, in our view, to be fruitful. We found that it provided a theoretically well-founded way of making comparisons over time and bringing significant changes into focus.

It may be suggested that using the structure of paradigms found in the study 1995 by Björklund (1999), Fig. 1, as a starting point of the exploration, has made the study less inductive and open than what is often aimed for in qualitative studies. To use a well-structured analytical approach, however, was essential to our comparative ambitions and made possible the quite detailed illumination of transformations of paradigms over time.

**World view transformations**

A growing insight into the environmental influence on the individual’s experience of ‘health’ is natural since the conceptual models of occupational performance presented at the occupational therapist program, for instance Kielhofner (1995a) and Townsend (1997), are composed of three interrelated components: the person, occupation and environment. Occupational performance is of vital importance for the individual’s experience of health according to another theorist, Wilcock (1998), presented at the program. One can assume that the environmental influences on health are further accentuated by the informants’ practical experiences in 2001.

The informants’ notions of ‘activity’ reveal an increasing awareness of the context as a qualifier for activity, but also the importance of the lived experience of activity. The appearance of this phenomenological perspective in occupational therapy was first described in occupational therapy literature by Mattingly and Fleming (1994) and by Kielhofner (1995b).

The revision of International Classification of Impairment, Disability and Health (ICIDH) (WHO, 1980) into ICIDH-2 (WHO, 1999) during the time period of this study has had a strong impact on the educational programme and on the informants’ views of ‘self-determination’. In ICIDH-2, the importance of contextual factors for the individual’s health condition is accentuated and this, together with their meeting with real life as occupational therapists, probably caused the fact that the environmental influences on self-determination are accounted for to an increasing extent during the time period.

Through the closer encounter with occupational therapy, in theory at the educational program as well as in reality in practice, the informants’ awareness of the multiplicity of occupational therapy work increases, but also their awareness of an occupational therapy focus on the consequences of trauma and disease for peoples’ occupational performance in daily life. This evolving experiential perspective is also reflected in the informants’ apprehensions of occupational therapists, which is displayed in a transformation from being an occupational therapist to acting as one.

**Field of action view transformations**

When it comes to goals for occupational therapy, the informants’ notions transformed from a mainly individual focused perspective to a more social view of a person’s lived experience of participation and activity. One can assume that the informants have been influenced by the practice situations surrounding individuals’ occupational performances, as in their stating that confidence and dignity are important qualifiers for an active life of the individual.

The informants’ notions of occupational therapy interventions transformed from a focus on the separate, most visible interventions to a perception of interventions structured in a process model, ending up in ‘enablement’ of activities by more embedded interventions in relation to the individual’s experiences of meaningfulness in life. It is natural that the students when entering the occupational therapy program display an outsider perspective of occupational therapy interventions and that a practitioner perspective develops through the encounters with theoretical practice models (Pelland, 1987; Townsend, 1997) and experiences of situations in practice.

The methods of occupational therapy are seldom named by the informants in this study (or in occupational therapy literature) but often hinted at indirectly by the way they described how occupational therapists implement their interventions in practice. These circumstances were verified by Björklund (2000), who suggested that an explanation for this phenomenon was that each encounter with the patient is explained as an encounter with a unique individual, in a unique situation, and therefore the method has to be created in the moment of implementation and is consequently impossible to decide beforehand. Borell (1993) takes an additional step in stating that it is the individual’s own activity that is the healing method of occupational therapy. If the individual’s own activity is to be regarded as the method in occupational therapy, and activities always are accomplished in an environment, it is natural to consider the environment as an important tool of occupational therapy.

What can be learned from this study? Our main finding is that paradigmatic changes on the personal level do occur through education and occupational therapy work experience. We have also experienced that Törnebohm’s theory of paradigms is a useful tool for examining and elucidating those changes. We believe this tool would be well suited to underpin cross-national comparative studies. We summarised the paradigmatic change among the informants from a ‘public view’, via a ‘theoretical view’, to an ‘experiential/contextual view’. The ‘public view’ that the students bring with them when they come to the
References


Appendix 1

Essay questions

1. Describe the occupational therapist’s principal tasks, methods and tools as you understand them.

2. Mention and characterise the most important goals of occupational therapy.

3. Give a summary of what interests you the most and the least in occupational therapy.

4a. (95/98): Based on your abilities, as you see them, what do you think will be easy and hard in your future professional practice as an OT?
4b. (01): Based on your abilities, as you see them, what do you think is easy and hard in your practise as an OT?

5. How would you describe the differences between the profession occupational therapist and other caring professions that you know about?

6. ‘Activity’ is a central concept within occupational therapy. What do you include in the term ‘activity’?

7. Describe what is meant by ‘to be in good health’.

8. Occupational therapy means working with people in hard life situations. How do you look at a person’s ability to influence her/his own situation?