Chapter 1

Occupation in Occupational Therapy: A Labour in Vain?

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1.1 Introduction

The title of this chapter is inspired by Australian penal history, in that one of the punishments used by prison officers in early Australia was called 'a labour in vain'. The precise nature of the punishment varied, but essentially it involved the prisoner engaging in a futile activity. One form of labour in vain was for prisoners to be given a metal bucket and told to polish it until the bucket shined. As the buckets were used as toilets or to clean out the prison cells there was no need for them to gleam, given that soon after the bucket had been polished it would once again be dirty: the task was futile and meaningless. At first thought, a labour in vain may seem nothing more than an interesting historical anecdote. It is my contention, however, that this early form of punishment is a useful way to consider modern occupational therapy practice. In particular, it is worth considering three key questions: do the people who receive occupational therapy as clients labour in vain, do individual occupational therapists labour in vain in their attempts to address the occupational needs of clients, and finally is the profession of occupational therapy labouring in vain in its attempts to raise awareness of the occupational needs of humans?

It is my suggestion that the answer to the first of these questions is yes, sometimes, but not always, occupational therapists do subject their clients to the clinical equivalent of a labour in vain. The answers to the remaining two questions are more complex. It is probably true that many, but not all, occupational therapists work in systems and environments which make it difficult to address the occupational needs of their clients. This is most often due to factors such as the dominance of the medical model, coupled with the significant political, institutional and financial pressures which characterize modern health and social care. The paradox, however, is that while occupational therapists are labouring to increase awareness of the occupational nature of humans, the relationship between occupation and health is becoming more widely accepted outside the profession. While it is

rarely, if ever, labelled occupation, an occupational perspective is indeed on the rise.

Given the history, philosophy and growing evidence base of the occupational therapy profession, this labouring in vain is construed here as undesirable and unnecessary. In order to illustrate this, this chapter will review the place of occupation in occupational therapy, consider current occupational therapy practice in the context of this heritage and make some suggestions as to how to reduce the labouring in vain. Of course these are very complex issues and it is therefore not possible to explore them in great depth, nor to provide all the answers, and so the aim of this chapter is to highlight them and stimulate thought, and hopefully action.

1.2 Occupation in occupational therapy

At the inception of occupational therapy, the concept of occupation held centre place within the philosophy of the profession. The founders of occupational therapy based the new profession on their own personal experiences of the health enhancing effects of engagement in purposeful and meaningful activity (Peloquin, 1991a, b). George Barton, for example, had first hand experience of the health benefits of occupation. After becoming paralysed on one side of his body following surgery for gangrenous toes, Barton established Consolation House in 1914 where he, and later others, engaged in workshop activities to improve their functioning. Susan Tracey, a nurse, saw the benefits of activity when she worked with patients on surgical wards. Convinced by those early experiences, she continued to use activity with patients in a variety of settings and eventually wrote and taught others about the therapeutic use of occupation. This way of working with people with physical disabilities and psychiatric conditions became popular, and the profession grew and expanded, first in the United States of America, and then gradually around the world. Kielhofner (1992) noted that for the early part of the twentieth century there was a degree of consensus regarding the assumptions which underpinned occupational therapy practice: the essential role of occupation in human life; the link between mind and body; that lack of occupation could result in poor health and dysfunction; and conversely, that occupation could be used to restore health and function. The history of the occupational therapy profession is well documented elsewhere (see for example Peloquin, 1991a, b; Reed, 1993; Schemm, 1994; Wilcock, 1998, 2001a, 2002), and while it is beyond the scope of this chapter to trace the profession's history, one recurring issue for the profession is worth considering.

Kielhofner (1992) has noted that the 1970s saw a growing dissatisfaction among occupational therapists with the mechanistic approach that gained favour in the preceding two decades. Occupational therapists in the 1970s came to realize that human beings did not merely equal the sum of their parts. Furthermore, the approaches to treatment that the mechanistic paradigm[1] fostered were found not

[1] A paradigm is the 'common vision of members of a profession' (Kielhofner, 1992, p. 15).

to meet the complex needs of people with disabilities. Interestingly, there was a call for a return to the occupational roots of the profession long before the crisis in the 1970s. Reilly (1962) called for therapists in the early 1960s to demonstrate not only the occupational nature of humans, but also the ability of the profession to address the occupational needs of people.

More recently, there is still some indication that the occupational needs of people have been neglected by occupational therapists working in traditional health services. For example, Little (1993), a wheelchair user, has suggested that occupational therapists should approach their work with people with disabilities with the aim of solving everyday problems. These problems might include not just getting dressed, but also going out in public and participating in life, which might involve how to enjoy a meal at a restaurant by feeding oneself while maintaining a sense of dignity. These seem to be problems of occupational performance, which should be the focus of occupational therapists. Throughout the history of the profession occupational therapists have recognized the deficiencies of practice and called for the profession to scrutinize the occupation-health relationship and return to occupational therapy practice grounded in occupation (Reilly, 1962; Rogers, 1984; West, 1984; Yerxa *et al.*, 1989; Yerxa, 1991).

1.3 Current occupational therapy practice

From tracing the passage of the occupational therapy profession through two previous paradigms Kielhofner suggested in 1992 that occupational therapy was developing a third paradigm which incorporated the strengths of previous ones (Kielhofner, 1992). More recently Kielhofner (1997) noted that the new paradigm was again only emerging and not yet fully formed. He proposed that three broad assumptions characterize this emerging paradigm. First, is that humans have an occupational nature. Second, that humans can experience occupational dysfunction. Third, that occupation can be used as a therapeutic agent. Table 1.1 presents these assumptions along with those of previous paradigms for comparison.

From reviewing the assumptions of previous paradigms, it is clear that the emerging one is rooted firmly in the original paradigm of occupation, and yet is different. Occupation is now the dominant construct which characterizes how occupational therapists understand humans, dysfunction and intervention. This change may appear subtle, but its significance is not to be underestimated. The view now is that humans are occupational beings, not merely that occupation is an important part of human life. Similarly, rather than viewing health and ill health in terms of damage to mind and/or body, it is now conceptualized from an occupational perspective as occupational dysfunction. The idea that occupation can facilitate the restoration of function has remained in the emerging paradigm. Although the reductionist approaches which grew in popularity during the mechanist period have largely fallen out of favour, this period of the profession's history has proved valuable (Wilcock, 1991). For example, 'an important heritage from the field's second, mechanistic paradigm is the recognition of the importance of the performance components to occupation (Kielhofner, 1992, p. 54).

Table 1.1 Assumptions central to each paradigm of occupational therapy. Adapted wtih permission from Kielhofner, G. (1992). *Conceptual Foundations of Occupational Therapy*. Philadelphia: F.A. Davis.

The paradigm of occupation (1900–1950)
• Occupation plays an essential role in human life and influences health
• Occupation consists of an alternation between modes of existing, thinking, and acting
• Mind and body are inextricably linked
• Lack of occupation can result in damage to mind and body
• Occupation can be used to restore function
The mechanistic paradigm (1960s)
• The ability to perform depends on integrity of body systems
• Damage or abnormal development of body systems can result in incapacity
• Functional performance can be restored by improving or compensating for system limitations
The emerging paradigm (1980–present day)
• Humans have an occupational nature
• Humans may experience occupational dysfunction
• Occupation can be used as a therapeutic agent

The suggestion that the occupational therapy profession is in the midst of an emerging paradigm of occupation, is supported by developments within the profession. Commenting on a published review of the north American professional literature between 1900 and 1990 (McColl *et al*., 1993), Whiteford *et al*. (2000) noted that the number of papers published which focused on occupation was initially large in the period up to 1950 (44.5% of all papers published on occupation between 1900 and 1950), this then dropped off to 19.3% between 1951 and 1980, but then increased to 36.2% in the 1981–1990 period. This is consistent with the foci of the three paradigms proposed by Kielhofner (1992) and further demonstrates that since 1980 there has been a 'resurgence of interest in occupation' (Wilcock, 1991, p. 74). The other key development has been the emergence and continued growth of occupational science. The first paper published on this topic appeared in 1989, in which it was defined as 'the study of the human as an occupational being including the need for and capacity to engage in and orchestrate daily occupations in the environment over the lifespan' (Yerxa *et al*., 1989, p. 6). It has been suggested that one of the strengths of this new field is that it will force occupational therapists to re-engage with their philosophy and return occupation to the centre of occupational therapy (Molineux, 2000), because the focus of occupational science is humans as occupational beings (Yerxa *et al*., 1989; Wilcock, 1993). In parallel to these developments within occupational therapy, there has been a general growing interest in occupation (although it is usually not given that name) by others outside occupational therapy (See Golledge, 1998; Wood, 1998; Molineux, 2001, 2002; for discussions of this issue).

Research from outside occupational therapy and occupational science is demonstrating the occupational nature of humans and the impact of occupation

on health. For example, the Health Walks Research and Development Unit (2000) at Oxford Brookes University has been investigating the health benefits of led walks in the countryside. The original walks project was instigated by a general practitioner and since then has been developed and scrutinized. Researchers in the unit have found that in addition to the obvious impact on physical fitness, participants also reap benefits due to the social aspect of the walks, and this is consistent with the multidimensional nature of occupation (Yerxa *et al*., 1989). The positive impact engaging in occupations has on survival has been demonstrated by a group of public health doctors in the United States of America (Glass *et al*., 1999). This study found that although, to use their categories, social activities (e.g. attending church, playing bingo, eating out at restaurants) and productive activities (e.g. gardening, shopping, paid or unpaid work) resulted in little, if any, improvement in physical fitness, they did lower the risk of death as much as fitness activities (e.g. walking, physical exercise). While the authors of this paper did not discuss their findings in relation to the health benefits of occupation, this study supports the link between occupation and health (Molineux, 1999; Rebeiro, 1999).

This growing acceptance of the value of occupation in the lives of humans is encouraging. However, it is also somewhat problematic for occupational therapists given the way in which the profession has developed. There is much anecdotal evidence to suggest that occupational therapists, who are the alleged experts in occupation, do not understand the construct and do not address the occupational needs of their clients in practice. For example, Wood (1998) recalled a telephone call in which her sister, a business journal publisher, bemoaned the results of sending out reporters to interview occupational therapists and physiotherapists. Her sister, who had a good understanding of occupational therapy, was dismayed when the reporters returned suggesting that the professions 'were more indistinguishable than not' (Wood, 1998, p. 403). From my own experience of visiting one particular occupational therapy department, I can fully understand how the reporters could see no difference between occupational therapy and physiotherapy. I arrived at the occupational therapy department and was walking to the office to meet the student I was visiting. On my way I passed a large room and witnessed an elderly woman dressed in a flowing sari pedalling a pedal fretsaw, with no wood in sight and not even a blade in the saw.

In his book about having a stroke and undergoing rehabilitation, the author and literary editor of the *Observer* newspaper, Robert McCrum (1998, p. 139) recalled that:

> 'The part of convalescence that I found most profoundly humiliating and depressing was occupational therapy... I was reduced to playing with brightly coloured plastic letters of the alphabet, like a three year-old, and passing absurdly simple recognition tests. Sitting in my wheelchair with my Day-Glo letter blocks I could not escape reflecting on the irony of the situation. If only Milan Kundera, Kazuo Ishiguro or Mario Vargas Llosa, whose texts I had pored over with their authors, could have seen their editor at that moment.'

Similarly, Gray (1998) reported on her discussions with one man who had received occupational therapy. When asked about his experiences he recalled only that he was asked to 'pick that up there and put it over there' (p. 354). These examples focus on clients with physical disabilities, as that is my own area of clinical experience, but there are similar concerns within the field of mental health (Yau, 1995; Lloyd *et al*., 1999). A survey of occupational therapists working in the UK in mental health conducted by Craik *et al*. (1998) demonstrated a level of role blurring. They found that 67% of their respondents felt they had carried out tasks such as giving advice about medication, testing urine for drugs and explaining blood test results. All of these accounts are powerful examples of practice which 'so heavily emphasizes performance components that it ceases to be occupational' (Gray, 1998, p. 354).

The futility of therapy which prioritises performance components over occupation has been powerfully demonstrated by Lewis (1987, p. 6) writing from a special education perspective. Lewis described an 18 year-old client, Daryl, who had been receiving a range of therapies and interventions due to an intellectual disability/learning disability. While Daryl had made progress this was of little use or relevance to him, as the excerpt below shows:

> 'He can sort blocks by colour, up to 10 different colours!
> But, he can't sort clothes; whites from colours for washing...
>
> He can roll Play Dough and make wonderful snakes!
> But, he can't roll bread dough and cut out biscuits...
>
> He can sit in a circle with appropriate behaviour and sing songs and play Duck, Duck, Goose.
> But, nobody else in his neighbourhood his age seems to want to do that.'

One of the reasons occupational therapists find themselves in these situations is their willingness and ability to adapt to situations (Wilcock, 2001b). While this is in many ways an admirable quality, it signifies a serious deficiency in occupational therapy; practice being dictated by the individual situation rather than a professional philosophy. This was explored by Fortune (2000) when she proposed that occupational therapists working in mental health may be 'gap fillers'. In her research she presented occupational therapists with a scenario that required them to consider and describe the potential role of occupational therapy in what could be seen as a non-traditional work situation. She found that the occupational therapists described their potential role in ways that suggested they were filling a gap, and that their practice was devoid of any philosophical touchstone. Their decisions about how they might contribute in the hypothetical situation were dependent on the make-up of the team, the exact nature of the service, and were not in any way related to the occupational therapy profession. It could be that this gap filling has led to what others have called role blurring, role overlap, and role ambiguity. To rephrase Fortune (2000), it is *paradigm-independent practice* which is the cause of the mismatch between current practice and the history of the profession. While this role as gap fillers does provide occupational therapists with

personal and professional identity within each work environment, it does place the profession in a very uncertain situation.

1.4 Refocusing on occupation

Working in ways that are not focused on occupation or grounded in an occupational perspective is not satisfying for individual occupational therapists, is not productive for the profession as a whole, but more importantly is not useful or meaningful for clients. Clients who experience occupational therapy like that described in the previous section are not able to reap the benefits of authentic occupational therapy. Furthermore, this is inappropriate because many clients actually want to improve their occupational performance or increase the range of occupations in which they engage, and are dissatisfied with the focus of traditional health and social care services. The solutions to the problems discussed so far are simultaneously simple and difficult. They are simple because they require occupational therapists to remember the heritage of their profession, but difficult because acting on that can be a challenge within modern work situations. All occupational therapists should, therefore, remember where they come from and, when working with clients, start where they mean to finish.

1.4.1 'Remember where you come from'

Over ten years ago, Wilcock (1991) usefully summarized the reasons why occupational therapists were not practising in ways consistent with the profession's heritage. She suggested that the construct of occupation was not fully understood by occupational therapists, probably because they have not valued the profession's philosophical base. This has resulted in 'the siphoning off of theory and philosophy from practice' (Wood, 1998, p. 404). It is, therefore, the case that many 'occupational therapists do not view the world, or work with their clients, from an occupational perspective' (Wilcock, 1991, p. 86). Instead the reductionist medical model way of viewing clients and their difficulties remains dominant in occupational therapy (Wilcock, 2000).

For some time now occupational therapy scholars have been calling for the profession to develop a philosophy which could guide education, research and practice (Reilly, 1958; Kielhofner, 1992; Yerxa, 1998; Wilcock, 1999). Wilcock (1999), drawing on earlier unpublished work of Doris Sym[2], provided strong arguments for why any profession, and in particular occupational therapy, needs a philosophy:

[2] Doris Sym was the founder and first principal of the Glasgow School of Occupational Therapy, Scotland, UK. In 1980 she delivered a paper at the College of Occupational Therapists' Annual Conference which explored changing professional attitudes.

- A profession based solely on skills, without a supporting philosophy, runs the risk of those skills being poached or duplicated by other professional groups, the adding and subtracting of skills when other professions change direction, or just remaining stuck in its ways.
- A philosophy would provide a common language with which occupational therapists could describe their practice. (Wilcock suggested that this might put an end to people viewing what occupational therapists do in different settings as completely unrelated.)
- A philosophy would provide a firm bedrock which future developments of the profession could be built on, and measured against, to ensure their congruence.

Although the emerging paradigm has been on the rise for some time now (Kielhofner, 1992, 1997), there is evidence to suggest that much occupational therapy practice today remains divorced from the assumptions which underpin this emerging paradigm. Although this divorce is problematic in itself, it is even more the case when one considers the growing research evidence to support an occupational view of humans, and the relationship between engagement in occupation and health (Fisher, 1998; Molineux, 2002). The reasons for this loss of occupation from occupational therapy can be identified by a review of the profession's history. Wilcock (1998) has suggested four factors: occupational therapy as prescription, the gender bias within the profession, the pursuit of professionalism and scientific reductionism.

The early influence of the medical profession over occupational therapy, like other allied health professions, meant that occupational therapy developed as a treatment that required prescription by a medical practitioner. There was very limited scope for an occupational therapist to make professional judgements about what was or was not appropriate, and in some countries that is still the case today. As Wilcock sees it, the heritage of occupational therapy as a prescribed treatment has inhibited research and development of a unique occupational perspective. The large number of women in the profession is another possible reason for the problems faced by the modern profession. Wilcock (1998, p. 190) suggests that despite early occupational therapists being proto-feminists with concerns for 'less educated or advantaged women . . . they accepted subordination to medicine in a way similar to gender segregation . . . of the day'. This subordination limited development of the profession as an autonomous group. There is little doubt that the alliance occupational therapy formed with medicine was beneficial for achieving greater recognition and in advancing research efforts. It is also the case, however, that while occupational therapy was dominated by medicine (e.g. requiring a prescription from a doctor in order to see a patient and having doctors in leadership positions within the professional bodies) it was virtually impossible to develop as a truly independent and autonomous profession. As discussed earlier, the mechanistic paradigm of the profession's history was one in which the link with medicine and a drive for a scientific basis resulted in a narrow focus on physical and psychological abilities. Despite the value of some knowledge and techniques developed during this period, an occupational

perspective was largely lost. Some have gone so far as to suggest that this period 'was a dark age in occupational therapy's history in which occupation was figuratively lost' (Whiteford *et al*., 2000, p. 63).

What is needed now, therefore, is for occupational therapists to re-engage with their heritage and remind themselves that they are *occupational* therapists. This will involve ensuring that clinical practice is congruent with the philosophy of the profession and the growing evidence base which exists to support it. It will require occupational therapists to articulate the uniqueness of the profession, and that is something that should not be avoided. After all, being unique is one of the hallmarks of a true profession (Reilly, 1958; Yerxa, 1967), as is the proud and vigorous use of the profession's particular media (Reilly, 1958).

The pervasive nature of occupation means that many professional groups will have some appreciation of occupation, but it is important to acknowledge that this is not to the same extent as occupational therapists. The occupational paradigm is what should bind all occupational therapists together. Although the precise ways in which therapists work might differ according to the particular models and approaches employed, all should be taking an occupational perspective. Making this change will mean the profession is no longer merely a gap filler, and that occupational therapists can rest easy knowing that practice is paradigm-dependent, and enjoy the sense of identity and role that brings. More importantly, however, occupational therapists can take comfort in knowing that the skills and knowledge of the profession are being used to maximal effect for clients.

1.4.2 'Start where you mean to finish'

While an occupational perspective is not new to occupational therapists, although many may have lost sight of it, the real challenge in the modern world is acting on that perspective. Because the remainder of this book includes many examples of how occupational therapists can, and do, practise in ways consistent with the professional philosophy, this will not be given great attention here. Before highlighting some ways in which implementing an occupational perspective in practice can be facilitated, one point is worth making. When confronted with a barrier to working in an occupational way with clients, occupational therapists must reflect on the situation and determine whether or not the barrier is real or merely perceived. While this may seem self-evident, I would argue that sometimes occupational therapists fail to overcome barriers because they make an inaccurate assessment of the nature of the barrier. A real barrier is one that is not amenable to change within the jurisdiction of the occupational therapist, the occupational therapy service (e.g. in a clinical setting) or the occupational therapy profession. A perceived barrier, on the other hand, is one that seems fixed, but on closer inspection and perhaps with slightly greater personal investment, is actually something that can be overcome. It is also important to remember that when seeking to implement occupational interventions seemingly small changes can pay large dividends.

The first aspect of 'starting where you mean to finish' is to recognize that

occupational therapists view humans and health differently from other professional groups. Rogers (1982) documented that occupational therapists are, by definition, more concerned with the occupational implications of disease than the disease itself. For example, disorder has traditionally been viewed within the medical model in terms of irregularity in the function and/or structure of the human body. Although this is changing, demonstrated by the *International Classification of Functioning and Disability* (World Health Organization, 2001), it is fair to say that many current health care systems remain dominated by this perspective. In contrast, occupational therapy views disorder as dysfunction in occupational performance which results 'in an inability to effectively accomplish daily tasks and to enact occupational roles' (Rogers, 1982, p. 31). Given that the focus is on occupational performance, it could be suggested that the precise pathology which has resulted in dysfunction is of little relevance to occupational therapists. Of course, this is not entirely true, but it is important that occupational therapists understand the relative importance of the two different constructs to their practice. The relationship between, and relative importance of, pathology and occupational performance have been documented in the professional literature. For example, in the clinical reasoning research conducted by Mattingly and Fleming (Fleming, 1991; Mattingly, 1991a, b; Mattingly & Fleming, 1994), while occupational therapists were found to be interested in the pathology of the client's condition, they were more concerned with how the individual experienced the condition. This issue has been incorporated into professional documents and frameworks which guide practice (see, for example, Canadian Association of Occupational Therapists, 1991; American Occupational Therapy Association, 1994, 2002), but two particular contributions to the professional knowledge base will be outlined very briefly.

The occupational diagnosis is a useful way of understanding client difficulties in occupational performance and it makes the relationship between occupational performance and underlying pathology explicit (Rogers & Holm, 1989; Rogers in Chapter 2). An occupational diagnosis is a statement that describes the way in which disease, disability, or any other factor, impacts on occupational performance (Rogers & Holm, 1989). As such, while not ignoring the underlying pathology, it gives primacy to the implications for occupational performance. This is discussed in more depth in the next chapter, but briefly the occupational diagnosis comprises four elements. First, is the descriptive element which describes the functional problem faced by the client. Second, is the explanatory component which describes the aetiology of the functional problem. Third, are the signs and symptoms which have provided the cues for the occupational therapist, and resulted in his/her ability to propose the aetiology of the difficulty. Finally, is the pathology which is the particular medical or psychiatric problem which underlies the functional problem and gives rise to the signs and symptoms. Even from this brief overview it is possible to see how conceptualizing client difficulties in this way requires the occupational therapist to focus first and foremost on the client's occupational performance difficulties.

The other useful way of ensuring a focus on occupation in clinical practice is to

ensure that assessments are occupationally focused. Hocking (2001) usefully proposed a framework for implementing occupation-based assessment, which demonstrates the relative importance of performance component deficits. The first task of assessment, in her framework, is to understand the client as an occupational being, that is, to understand 'the meanings [clients] experience and express through occupation' (p. 464). Next, is to understand the function those occupations serve in the context of the client's daily life, overall lifestyle, and even how those occupations impact on other individuals. The third stage requires the occupational therapist to gain an understanding of the form of the particular occupation in question, by attending to 'the nature and extent of any observable disruption to performance and identifying occupational performance skills and environmental opportunities that support performance' (p. 465). It is only at this stage in the process that the occupational therapist begins to examine (in detail) deficits in occupational performance components. The strength of this framework is that it places understanding the client as a unique occupational being at the start of the assessment process. In doing so it delays attention to performance components until it can be used effectively within a wider occupational perspective.

The key to 'starting where you mean to finish' lies in the focus of the assessment stage of the occupational therapy process. Given that assessment guides subsequent treatment planning and implementation, it is important to ensure that assessment focuses on what occupational therapists can and should be helping clients to address: problems with performing and managing occupations. After all, 'therapists who focus their evaluations solely on performance components risk focusing treatment around those components, thus failing to address critical occupational issues'. (Hocking, 2001, p. 463)

1.5 Conclusion

This chapter has proposed that aspects of modern occupational therapy practice may be likened to the early Australian prison punishment, a labour in vain. From a review of some of the literature which has examined and critiqued current clinic practice it seems that there may be some substance in this assertion. Paradoxically, there are developments within and outside the profession which mean that it is probably possible to minimize, if not completely eliminate, the need for occupational therapists and, more importantly, our clients, to labour in vain. The occupational therapy profession is founded on a sound philosophy which is now supported by a growing evidence base. Most exciting, is that some of the evidence is being generated outside occupational therapy and so it is clear that an occupational perspective is gaining acceptance. Two maxims for occupational therapy practitioners have been proposed: 'remember where you are coming from' and 'start where you mean to finish'. Practice guided by these principles will be based on the professional philosophy of occupation and health, and will focus from the outset on the occupational needs of our clients. While it is recognized that working in an occupationally focused manner is challenging in many health and social care

environments of today, it is also recognized that not working in that way is to deny our clients the full benefits of occupational therapy. Let future occupational therapy labours not be in vain and our clients' experiences of occupational therapy be meaningful and relevant to their everyday lives.

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Chapter 6

On Watching Paint Dry: An Exploration of Boredom

Cathy Long

6.1 Introduction

'Like watching paint dry' is a commonly used simile for any experience which is found to be dull, unstimulating or just plain boring. The function of a simile is to illustrate the nature of something by making a comparison to something else, but it can also mask the real impact of the experience. Hence, 'like watching paint dry' may diminish the potentially destructive experience of boredom. Boredom is an under-researched phenomenon within occupational therapy literature and, indeed, there seems to be a paucity of research more broadly. Consequently it seems to be a little understood phenomenon. In spite of this, I will try to show that boredom is of relevance to occupational therapy practice, to our clients and possibly to ourselves.

Hutchinson (1998), writing from a user perspective, described her feeling of abandonment and alienation on admission to a psychiatric ward and refers to the relentless tedium of being an inpatient. She also highlights the consequences of some of our professional concerns:

> 'As far as boredom is concerned, my evaluations highlighted a problem – trained nurses did not consider it to be in their remit to ''entertain'' patients, and occupational therapists becoming ever more sophisticated and anxious to lose their ''stuffed toy'' image, would only do so if it was part of a patient's treatment.' (Hutchinson, 1998, p. 17)

As an occupational therapist working on an acute psychiatric ward in the early 1990s, I can remember that reluctance to engage with clients on the sole basis of their needing something to do. Interestingly, wise nursing colleagues avoided using any terms that alluded to boredom when referring people to occupational therapy, having learnt that these were perceived as unacceptable or inappropriate reasons for referral. It is likely that some of the clients on the ward did experience boredom, but as it was a question that was rarely, if ever asked, it is difficult to be sure. Perhaps, more importantly, the extent to which boredom was a characteristic

of these people's lives prior to admission, or whether it continued to be a problem on leaving the hospital, was never explored. This also raises questions about how boredom impacts on a person's health and well-being, whether it affects the process of recovery, and if so in what sort of ways.

There are no easy answers to these questions and it is beyond the remit of this chapter to provide definite answers. Rather, the aim is to explore boredom and to tentatively suggest ways in which this applies to working with people in therapeutic contexts. Therefore, the first part of the chapter provides an overview of boredom-focused research, including definitions and factors influencing its occurrence, whilst the second part discusses how this relates to occupational therapy practice. Because boredom is an under-researched area I have tended to rely heavily on a few key articles and for the same reason suggestions for practice are general and tentative.

6.2 Overview

The aim of this first section is to summarize the complex and often conflicting debate regarding definitions of boredom. This will be followed by a discussion of factors influencing its occurrence in relation to the individual, the task, and the environment. Finally, the possible consequences of boredom and how activity has been used as a remedy to it, will be considered.

6.2.1 Defining boredom

It is likely that we can all identify the experience of being bored in ourselves, yet a widely accepted definition of boredom remains elusive. As a consequence there are many and sometimes conflicting opinions as to how to define the phenomenon. For example, it would be reasonable to think that boredom is simply a lack of interest in a subject, situation or activity. However, according to research literature it appears that the experience of boredom is far more complex and perhaps escapes precise classification.

In simple terms, boredom may be defined as being in a state of too low complexity (Mikulas & Vodanovich, 1993). In other words the activity being undertaken is insufficiently demanding in relation to the individual's physical or cognitive capacity. Furthermore Mikulas and Vodanovich (1993) suggest that the resulting state of boredom is necessarily an uncomfortable one. This may be illustrated by considering behaviour associated with the state of being bored: restlessness, pacing, yawning, sighing, fiddling and fidgeting, gazing out of the window, becoming fascinated by minutiae. When boredom is extreme the individual seems to desire to escape either the source of their boredom, or the state itself, finding any distraction to remove themselves from the situation.

> 'To feel bored is to suffer, in however slight a degree and for however short a duration. That is to say it is a state from which one would like to be set free, from which one seeks relief even, perhaps with desperation.' (Healey, 1984, p. 28)

It is important to make a distinction between boredom and depression as there is some evidence that they can appear very similar to each other in that they both involve an absence of interest in activity or in one's circumstances (Barbalet, 1999). However, Barbalet (1999) makes a distinction by suggesting that depression is often inwardly directed towards the self, whilst boredom tends to be outwardly directed towards the activity or the environment.

For most of us the experience of boredom is transient. However, Gabriel (1988) presents case vignettes of adults who experience chronic boredom, a phenomenon which Fisher (1993) labels as pathological boredom. This can be best illustrated by quoting from one of Gabriel's vignettes. Frances recalls:

> 'When I am bored I feel nothing. Nothing moves me at all. I feel like I am existing and doing nothing but waiting for time to pass, to go by. I just want to finish whatever I have to do. I have had this feeling for years. I don't feel sad but I am not happy. I just feel a sort of nothingness. Nothing interests me.' (Gabriel, 1988, p. 160)

Significantly all of the people Gabriel interviewed made distinctions between their experiences of boredom and depression. Having experienced both, they were able to identify and articulate differences which although seemingly semantic, may highlight some of the inadequacies of the English language in identifying and communicating our precise feelings and experiences. Fisher (1993) suggests that how people recognize boredom and how they use the word to describe what they are experiencing, are of importance when analysing the phenomenon of boredom. This suggests that in a therapeutic context it is worthwhile exploring the client's 'felt' experience of boredom as it is likely that people use the term idiosyncratically.

6.2.2 Factors influencing boredom

All boredom-focused research makes reference to the individual, the environment or the activity when considering causal factors. This concept is not new to occupational therapists in relation to human occupation. For example the person-environment-occupation model (Law *et al.*, 1999) provides a framework for analysing and conceptualizing occupational performance in relation to the complex interaction between these three domains. The extent to which a person is satisfied with their performance is one of the indicators of the degree of fit between person-environment-occupation. In the context of the current discussion, the issue is how boredom, as a subjective experience, influences a person's performance and/or their perception of it. In the interest of clarity the same domains have been used for this subsection but this is not to suggest that the factors fit neatly into one or other category. All of these aspects interact with each other so there is inevitably much overlap between them.

Individual influences on boredom

One important area of study in relation to the individual has been the development of the Boredom Proneness (BP) Scale. Devised by Farmer and Sundberg (1986), it has been used as a means of measuring the extent to which individuals are susceptible to experiencing boredom. The most recent version, as described by Vodanovich and Kass (1990), uses a Likert scale of 28 items, on a self-report basis. Overall, the items emphasize: the extent to which a person feels connected with their environment; their ability to use adaptive resources to overcome feelings of boredom; and their capacity to recognize and use personal competencies.

Vodanovich and Kass (1990) further analysed the items of the BP scale with the purpose of enabling a deeper understanding of the overall score. They suggest that although two individuals may have the same score, the factors underlying their susceptibility to boredom may be very different. For example, one person's scores may indicate fewer personal strategies for effective time use, whilst someone else's may indicate a predominance of working below their competencies. They suggest that having a greater understanding of these underlying factors may be of particular benefit when deciding upon interventions in a therapeutic capacity. Despite this comment the BP scale has been most extensively used with undergraduate students and appears to have had limited application in therapeutic settings. However, there is some tentative evidence which suggests that some people are more vulnerable to boredom than others, at least amongst undergraduate students (Farmer & Sundberg, 1986).

A further aspect associated with personal influences on boredom is the extent to which we attribute meaning to our actions. Barbalet (1999) suggests meaning is not an intrinsic aspect of objects or actions, but it is the person who gives them meaning, and these meanings provide the purpose and context to our actions. Thus, a bored student may not be able to see any relevance in the lecture material and therefore cannot elicit any personal meaning or purpose from their presence in the classroom. Similar findings were reported by Rudman *et al*. (1996) in their study of the meaning senior citizens attached to their occupations. The informants indicated that doing activity promotes the feeling that time is passing quickly, suggesting that their activities helped to alleviate boredom as, when bored, it is usual that time passes all too slowly.

Perkins and Hill (1985) expand on this idea of meaning by making a link between the significance of the activity and the protagonist's motivations. When these are congruent the activity is perceived and experienced as having meaning and is therefore not considered boring. It would be reasonable to suppose that repetitive tasks are generally experienced as boring, but studies have shown that the meaning of the task is more important than monotony (Fiske & Maddi, 1961 cited by Perkins & Hill, 1985). Monotony as a precursor to boredom has been extensively studied, especially in relation to repetitive work-based tasks. However, Perkins and Hill (1985) suggest that monotony is not sufficient for the experience of boredom, as not everyone who is involved with monotonous work

feels bored. They hypothesize that it is the person's perception of the work as monotonous which leads to boredom.

Environmental influences on boredom

Fisher (1993), in her discussion of possible causes of boredom in the work place, focused on the relationship between the experience of a task as boring and the external environment. Through her research she found that work colleagues can provide either direct stimulation (through conversation or sharing of a joke) or indirect stimulation (by their mere presence). Thus, it would seem that the social environment of the work place has a role in helping to alleviate boredom. However, some of Fisher's research respondents indicated that they experienced the exact reverse and felt boredom in relation to their co-workers, because they were perceived to be uninteresting or unfriendly, for example. Furthermore she cites research which suggests that the experience of boredom might be subject to social influence: people are more likely to experience a work task as boring if they are told that the task they have been asked to do is routine and unchallenging.

An in-depth ethnographic study by Charlton and Hertz (1989) graphically illustrates how the environment can influence boredom. Their research examined the work of security specialists of the United States Air Force (USAF), whose sole responsibility was to guard nuclear weapons against outside interference. The researchers doubted whether anyone would argue that this was an extremely important job, carrying a huge responsibility, but interviews with the workers highlighted the extreme levels of boredom associated with the role. Although highly trained USAF personnel, their job involved doing nothing for hours on end except observing an unchanging landscape. They perceived their biggest challenge to be one of coping with the unrelenting boredom in a context of a rigid organizational hierarchy, with strict punishments for misconduct.

Even though this is an extreme example, organizations that reduce the amount of stimulation and variety in the work place by imposing inflexible rules (for example, prohibiting talking, giving exact working procedures or limiting the number of breaks from routine) are more likely to engender boredom amongst workers (Fisher, 1993). Likewise, the greater the external control in performing tasks the greater the likelihood of experiencing boredom in relation to it (Fisher, 1993). In other words many work tasks may be experienced as boring simply due to the amount of external pressure to complete the task in a particular way; this seems to take away from enjoyment of the task itself. Similarly, Duncan-Myers and Huebner (2000) studied the relationship between choice and quality of life amongst residents in long-term care facilities. Their findings support previous studies showing that making choices is one way of increasing internal locus of control. Whiteford (1997), in an investigation of time use with a group of inmates in a maximum security prison, found boredom arose from an environment which severely limited opportunities to engage in occupation. Hence, environments which permit and enable individuals to make choices and to have some auton-

omy, are more likely to provide stimulation and participation, and are therefore less likely to provoke boredom.

Shaw *et al*. (1996) examined the experiences of boredom, time stress (defined as having too little time and too much to do) and lack of choices in the daily lives of adolescents. They suggest that the world is constructed by and for adults, a world from which adolescents are largely excluded. Shaw *et al*. hypothesized that it is this exclusion which leads to adolescents experiencing boredom. One of the aims of their study was to gain insights into the manner in which the dominant adult culture influences and directs the daily lives of adolescents. In school, boredom was more likely to be experienced when the students felt alienated by adult control or authority, for example being put down or humiliated in the classroom. In these situations they seemed to respond by passive non-participation which then led on to feelings of boredom.

Boredom arising from activity

The term 'activity', as opposed to 'occupation', has been used intentionally, as occupation is closely associated with a personal sense of purpose, engagement, value and meaning (Yerxa, 1994; Golledge, 1998; Law *et al*., 1999). This distinction is particularly important here, as, by definition, boredom is experienced when these core conditions are absent. Indeed a person may not subjectively experience their daily activities as occupations for these very reasons. For example, people who are depressed commonly lose a sense of meaning or purpose in their actions and may experience a sense of disengagement from their occupations.

This suggests that there is a crucial relationship between the individual and the activity which influences the experience of boredom. A brief mention of Csikszentmihalyi and Csikszentmihalyi's (1995) work on flow may help to explain this relationship more fully. They found, through investigation, that people have an intrinsic drive to seek challenges which are greater than their own personal abilities, in order to utilize and further develop their skills. When personal skill and external challenge were equally matched, the subjective experience of the activity improved greatly and intrinsic pleasure was heightened; a phenomenon known as flow. Rebeiro (2001) emphasized flow as an encouragement to occupational behaviour because activities that produce it are more likely to be continued. Also, because flow involves an absorption in an activity, she suggests that awareness of all of life's usual anxieties, monotonies and concerns are less likely to be an intrusion.

Occupational therapy literature emphasizes the importance of personal interest in relation to activity choice and it is reasonable to assume that some personal interest in an object/situation is vital in order to prevent boredom. For example, Matsutsuyu (1969), when establishing a theoretical foundation for an interest checklist, suggested that interests provoke an emotional response which leads us to make choices, and drives us into effective action. Thus, it is the interest which both initiates and maintains action. However, she also suggested that levels of interest can vary in their intensity, most especially when interests become

incorporated into the routine of life, and the initial enthusiasm for a particular interest has waned. This indicates that it is possible to feel bored by subjects or activities of personal interest, even if only temporarily. Hence both sources and levels of interest may change over time. Furthermore, there is some suggestion that boredom has a positive role to play in adaptation, being the prompt to our searching out new experiences, ideas or interests by directing us to actions or activities which are more meaningful to us (Vodanovich & Kass, 1990; Barbalet, 1999).

6.2.3 Consequences of boredom

The majority of research in this area focuses on the work place, but even here empirical evidence is limited as tools for measuring boredom are lacking, and boredom is generally ill defined and poorly understood (Fisher, 1993). As a consequence the short- or long-term effects of boredom on health and well-being are largely unknown. However Fisher (1993) indicates that boredom at work can have serious repercussions, for example an increase in numbers of mistakes or accidents, emotional upsets, stress, increased thrill seeking behaviour or risk taking and increased levels of hostility.

Charlton and Hertz's (1989) study demonstrates this, as their research brought to light the ways in which the USAF guards coped with the unrelenting boredom of their work. These ranged from 'authorized' strategies (i.e. those not banned by regulations) to 'high risk' methods. Reading a study manual provided by the Air Force was an example of an authorized strategy. Listening to radios, reading magazines or watching small screen televisions were all restricted activities and subject to severe penalties. In spite of this, many guards participated in this type of activity and described getting more tangible boredom relief from using such high risk methods. Destructive activity was also in evidence as guards described picking holes in the dashboard or seating of patrol vehicles, seemingly as a direct consequence of the stress associated with their boring job. However, these strategies did not appear to eliminate adverse effects to their health and well-being, as the guards pointed to psychological consequences. Some mentioned depression and many talked of difficulty in maintaining morale.

Rule breaking is often assumed to be a consequence of boredom, most especially amongst juveniles, and remains a firmly held belief despite a lack of evidence to support it (Newburn & Hagell, 1994; Farnworth, 2000). Newburn and Hagell (1994) interviewed persistent young offenders and revealed that although a mixture of chaos, sadness and boredom were common characteristics of their lives, a causal link between these experiences and offending behaviour was not found. However, there is some evidence that society can influence boredom, at least among this age group. For example, students who are most bored perceive themselves as least able to meet societal expectations and are often most marginalized by society (Farnworth, 2000).

6.2.4 Occupation as an antidote to boredom

A further theme of direct relevance to occupational therapy practice is how occupation has been used as a remedy for boredom. However, there is limited documented evidence showing how occupation has been used in this way.

As has been shown, Charlton and Hertz's (1989) study indicates some of the strategies the guards adopted to cope with high levels of boredom. However, the study also revealed seemingly pointless activities instigated by superiors to help make time go faster, described by the guards as 'making work'. For example, the guards were made to run around in circles or measure gaps in the fences being guarded. These activities were non-productive in the traditional sense, but given the importance of the task it could be argued that, from the superiors' perspective, the alleviation of boredom by any means was vital.

One study, which illustrates how users of a psychiatric hospital used occupational therapy as a means of relieving boredom, was carried out by Polemni-Walker *et al*. (1992). They explored the reasons why people admitted to a psychiatric hospital participated in occupational therapy groups by comparing views of users of the programmes with those of the occupational therapists facilitating the groups. They found that the widest discrepancy related to 'participation as a diversion from the tedium of the hospital routine', with users rating this more highly than the therapists. Overall the therapists rated the specific therapeutic gains of the programme more highly, for example the development of coping skills. The researchers suggest that there is nothing wrong with the user's diversionary motive, but question whether people who view this as their *primary* reason for participation are gaining the most from occupational therapy. However, Polemni-Walker *et al*. also expressed concern that the users involved in the study were communicating that they did not have enough to do whilst in hospital and that this could have had a negative impact on their recovery.

Perrin (2001) presented a similar argument, albeit with a different emphasis, by highlighting the importance of creativity to life and health, and expressing her sadness that occupational therapists in continuing care settings have moved away from using creative activities with clients. Where creative activity sits in relation to boredom is less than clear, as they are not associated in the literature, but it is likely that, by its very nature, engagement in creative endeavour excludes boredom.

Mee and Sumsion (2001) embraced this notion more fully in their study of users of different community mental health services. Some of the perceived benefits of engagement in occupation that emerged from their interviews reflect some of the themes discussed in this chapter. For example, users reported that the environment helped them find intrinsic motivation and enabled socialization. Having somewhere purposeful to go and fill time in a meaningful way prevented boredom and helped the participants to find meaning in their lives.

In summary, research indicates that boredom is an uncomfortable state of mind, manifested in physical behaviours. Boredom may impact adversely on psychological well-being, but it may also be a driving force for positive action. Boredom

may arise from a mismatch between environmental challenge and skill, specifically where the individual is under-challenged in relation to their skill level, or it may arise from incongruity between the activity and the individual's needs, desires or motivations. Environments which allow individuals to exert personal control, make choices or provide opportunities to utilize skills are, according to the literature, least likely to provoke boredom. However, there are also suggestions that some people may be more vulnerable to boredom or have fewer personal capacities to seek out new avenues for stimulation.

6.3 Implications for occupational therapy

This section draws attention to the relevance of the literature discussed previously to occupational therapy practice by proposing general points that may be applied to any health or social care field. It should be noted that none of the following suggestions are new; they all relate closely to best occupational therapy practice. Indeed, it is likely that client-centred occupational therapy unwittingly addresses issues of boredom by, for example, ensuring therapeutic interventions have both meaning and purpose to the client. However, what is different is the conscious acceptance and acknowledgement of boredom as a potential problem for the clients we work with. A discussion of professional considerations follows, with the proviso that the issues surrounding boredom, with regard to particular client groups, environments or interventions require further research.

6.3.1 Environmental factors

It is evident that some environments yield more feelings of boredom than others and that these feelings, especially if prolonged, could have a detrimental effect on a person's health and well-being. For this reason boredom must be a consideration for anyone who is living in restricted and unstimulating environments, as this is where it is likely to be most manifest. Psychiatric inpatient wards, residential accommodation, prisons or other institutions providing long-term care would be examples of these. However, it should be remembered that non-institutional living environments may also restrict occupational opportunities or choices and not having the means to fill time in a meaningful way may be a problem for some clients. For example, people with impaired physical mobility, who find it difficult to get out and consequently have limited access to resources, may find their opportunities for occupational engagement limited and may therefore experience boredom.

Equally, the social environment of therapy is a possible influence of a client's perception and experience of occupational therapy. There are some situations, outpatient settings for example, where clients have an opportunity to discuss their experiences of occupational therapy on an informal basis. It is possible that clients who are bored by their therapy, who do not fully understand its purpose, may negatively influence the perception of others. This is likely to need managing in

some way, ideally by working with those who are expressing negativity in order to ascertain how their needs could best be met. Conversely, as all group therapists know, the social environment of the group can, with careful facilitation, encourage participation, motivation and engagement.

6.3.2 Occupational therapy practice

There are at least two ways of viewing the implications for occupational therapy practice. First, is the question of whether or not occupational therapists should simply provide activity as a means of filling the spaces in people's lives. Second, is whether or not the efforts of the profession would be better placed in enabling people to develop more adaptive time use skills. The latter approach is, perhaps, a more valuable and direct means of developing strategies and personal resources which a person could then apply in their everyday life.

Furthermore, it is generally recognized that occupational therapy is in itself a scarce resource and so services need to be allocated with some care according to prioritized need. For example, those people who have limited personal capacities to use resources available to them should, arguably, have our attention more than people who, with the right resources, in a suitable environment would be more able to use time in a meaningful way. This all suggests establishing some means of finding out about how the client experiences boredom, how extensive the problem is and the possible causative factors. One way would be through careful questioning and discussion at the assessment stage.

However, this whole approach fails to help those people whose health or process of recovery may suffer due to the absence of something to do. Herein lies an acute professional dilemma: the extent to which we should provide opportunities for clients to escape the monotony of, for example, hospital routines. For some this may be a very valuable intervention, but it does need consideration in relation to our specific skills and in relation to each particular environment. This is where hard and fast rules are less than helpful. Participation in a low level parallel group while on an inpatient psychiatric ward, for example, might be the starting point for occupational engagement, for some clients. For others the group may provide a diversion from pressing concerns or anxieties. In these circumstances, the client may not be able to aim for more than that, or gain anything more meaningful from the experience. It is also important to remember that periods of quiet contemplation within the therapy process are equally necessary; boredom is not necessarily all bad.

One final thought on our professional dilemma. It would be interesting to investigate whether other health and social care professionals are as concerned, as occupational therapists appear to be, about being perceived as providing boredom relief. For example, would art therapists, clinical psychologists, physiotherapists or others be concerned if their clients perceived their therapy as nothing more than a break from their usual routines? If not, it would indicate that perhaps Hutchinson's (1998) evaluations were right and our dilemma has more to do with wanting to eschew our stuffed-toy image than client need.

6.4 Future research

The majority of research in this area comes from outside hospital and social care settings, and so there is a pressing need for further investigation in relation to these environments, either with users themselves or through health and social care staff. The lived experience of boredom amongst different client groups is undocumented and a better understanding of the issues for particular people and environments would facilitate the development of effective assessment and intervention strategies.

Boredom, from a developmental perspective, has been under-researched and so little is known about how people develop resources to prevent or cope with boredom, and whether strategies change over time. It seems likely, however, that someone at 16 years of age will experience and deal with boredom in a different way to someone who is 70 years of age. Similarly, gender or cultural differences in the experience of boredom, or of the development of personal resources to deal with it, remain unexplored. Again, a greater understanding of how we develop inner resources and of any differences based on gender or culture would help with the progress of effective intervention strategies.

6.5 Conclusion

The ways in which boredom influences people's lives and their occupational performance is little understood, but it is likely to be experienced by some of our clients in some circumstances and may be more of a problem for some than for others. For this reason it is a possible area of intervention for occupational therapists but not necessarily by simply providing activity to fill the gaps in people's lives. This may be a useful intervention for some clients but could perhaps be most effectively provided by other agencies and personnel. For example activity coordinators on inpatient psychiatric wards are in an excellent position to meet this need. Our skills as occupational therapists are perhaps better placed in the development of a bottom-up approach to boredom relief. In other words the development of intervention strategies that enable clients to cope with boredom if it is an ongoing problem, impacting on their health and well-being. However, more research is required before precise recommendations about the nature and design of such strategies can be made.

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