Occupational Therapists in India Working with Neurological Rehabilitation

Jannice Meyer
Rebecca Nilsson

Occupational therapy

Luleå University of Technology
Department of Health Sciences
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Arbetsterapeuter i Indien och deras arbete med neurologisk rehabilitering

Jannice Meyer
Rebecca Nilsson

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Supervisor: Maria Prellwitz, Lecturer of Occupational Therapy
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*We will never forget this journey, which resulted in this study but also in so much valuable knowledge that we carry with us throughout life.*

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Sammanfattning


Keywords: Developing countries, India, Neurological disorders, Occupational therapy.
Abstract

The purpose of this study was to illuminate how occupational therapists in India describe and enact their work with rehabilitation of patients with neurological disorders. Method: Data collection was conducted by semi-structured interviews and unstructured non-participated observation in India at three private hospitals with 22 occupational therapists and four final-year master’s students. Data was analysed using a qualitative content analysis that resulted in three categories. Results: The categories were: Economy and family factors affect the rehabilitation, Client-centred practice and Following the OT-Process. At private hospitals in India, the patient's economical resources decide, to some extent, the rehabilitation approach. The family also influences the rehabilitation process both positively and negatively. The result describes how the occupational therapist is expected to set goals and arrange the patient's rehabilitation. The occupational therapist also described that training was conducted in activity however only functional training was observed. The conclusion of this study is that the participants used functional training as the main way of rehabilitating patients, which is different from the core of occupational therapy, where activity is the focus in rehabilitation used as both the goal and mean of achieving goals. Their way of working with rehabilitation in their country can still be interpreted effective along their working conditions and resources. Implications for clinical practice can be a better understanding of how occupational therapists are working in India and the value of continued critical thinking within the profession and the value of evidence.

Keywords: Developing countries, India, Neurological disorders, Occupational therapy.
Introduction

An overview by Brainin, Teuschl and Kalra (2007) shows that the quality and quantity of health care is largely patchy in low-income countries, with areas of excellence intermixed with areas of severe need, depending upon patients’ location, socioeconomic status, education and cultural beliefs. India is a country with different culture and society and not much research done of how occupational therapists work. With a pre-understanding from Swedish fieldwork and studies in occupational therapy, the authors decided to illuminate how occupational therapists in India describe and enact their work with patients with neurological disorders.

Background

Disability issues are rarely priorities for action in developing countries. Prejudicial attitudes against people with disabilities among the community are common and opportunities for independence are few. As a result, people with disabilities are frequently marginalized within their communities and have limited access to education and employment and thereby unlikely to be able to secure an income and independence (Coleridge, 1993). According to an Oxfam report (Coleridge, 1993)
there is a number of pressing needs for disabled people in India. Analysis of these needs showed that, through application of basic occupational therapy philosophy and skills, occupational therapists have a unique contribution to improve the quality of life for people with disabilities in developing countries.

In many developed countries, occupational therapy interventions are a part of early rehabilitation after a neurological disorder. This in order to improve the outcome for patients in activity of daily life and social participation, according to National Clinical Guidelines (Townsend & Polatajko, 2007). In these guidelines the occupational therapists are an important member of a multidisciplinary team in the rehabilitation process (Horn & Dejong, Smout, 2005; Steultjens & Dekker, Bouter, Jellema, Bakker, van den Ende, 2003; Landi & Cesari, Onder, Lattanzio, Gravina, 2006).
Occupational therapy's emergence

Occupational therapy as a profession is in continuous development and the profession's history shows a significant development in a relatively short period of time. The use of activities affect on health goes far back in time to Egyptian's use of activity in healing. Furthermore, the profession started early in the beginning of the nineteenth century, with focus on activities for people with mental illness (Blesedell Crepeau & Cohn, Boyt Schell, 2009). The treatment of the mental illness shifted toward a more humanitarian approach. Where the moral treatment was the most fundamental practice with the intention to replace brutality with kindness and idleness with occupation. The patients became active through occupations like music, dancing, singing, hunting, fishing and also chemical and mathematical studies (Blesedell Crepeau & Cohn, Boyt Schell, 2009). The roots of the profession was characterized by humanistic approach but change toward an increasingly mechanistic practice, were the focus was more on body parts and isolated functions, rather then the focus on occupation and the meaning in engagement. This gap created a growing crisis in the profession and a need for the paradigm of occupation to continue to develop. This need lead to theory and models explaining occupation such as Model of Human Occupation, MoHO, (Kielhofner, 2008). Striving after a holistic perspective to understand human occupational, while incorporation contemporary theory and concepts. This basis in which theory and practice where brought closer together resulted in an occupational therapy process model, a guideline for occupational therapist in there fieldwork. Overall, the focus of training in occupation and not in function had become the sign in the professions practice, and from then on the focus for the profession is to increase a higher science and evidence practice by all occupational therapists in the discipline (Blesedell Crepeau & Cohn, Boyt Schell, 2009).

Occupational therapy's core

The core in occupational therapy, health and quality of life are considered to be strongly influenced by having choice, control and the ability to engage in everyday life occupations (Law & Steinweinder, Leclair, 1998; Christiansen & Backman, Little, Nguyen,1999; Fischer, 2006). In order to deliver high-quality occupational therapy, the occupational therapists have to gain an understanding of the patients’ experiences, life worlds and expectations. The use of meaningful occupations in
interventions is considered to have a valuable outcome (Hammel, 2001; Whiteford & Townsend, Hocking, 2000). A previous study indicates occupational therapists ability to create an optimum condition for successful rehabilitation through effective use of everyday life occupation and environments (Govender & Kalra, 2007). Evidence shows that everyday life occupation should be used in rehabilitation for patients with neurological disorders (Kristiansen & Persson, Nygren, Boll, Matzen, 2011). Patients, who receive occupational therapy in early stage, in the hospital, have a greater level of independence in everyday life occupations, compared to patients that do not receive occupational therapy (Landi & Cesari, Ondor, Lattanzion, Gravina, 2006).

**Client in the centre**

The statement, that the individual is the one and only who is expert in their own lives, includes in the concept client-centred and many carries great knowledge of how to best maintain and improve their own health (Blesedell Crepeau & Cohn, Boyt Schell, 2009; Wilcock, 2007). Furthermore Wilcock (2006) emphasizes that all client-centred work is based on the individual's needs and abilities. They claim that an individual carrying both the experience and knowledge about their own lives. Therefore, the individual should be an active part in the occupational therapy process in which each person can do conscious choices in life and has a capacity to self-determination. Working along the concept includes the occupational therapists to demonstrate respect for patients, involve patients in decision-making, meeting their needs and recognizing their experience and knowledge (Canadian Association of Occupational Therapists, 1997). Research has shown that client-centred practice improves satisfaction with services, increases adherence to therapy recommendations, and improves functional outcome in activity of daily life (Neistad, 1995; McAndrew & McMermott, Vitzakovitch, Waruneck, Holm, 1999; Maitra & Erway, 2006). In occupational therapy the concept of client-centred practice is widely accepted. According to Panelpha (2008) client-centred practice can be seen in different occupational therapy models; The Occupational Performance Model (OPM), Model of Human Occupations (MoHO), Occupational Adaptation Model (OA) and Person-Environment- Occupational Performance Model (PEOP).
There are similarities in the client-centred and family-centred care, which are to cooperate and also make them form coping strategies, which is an important factor for them to manage the situation (Panelpha, 2008). Families have an important part and are the patients primary caregivers and can affect the patient's experience of their disability and are therefore a factor to include in the rehabilitation. The family centring is more then just adding family members into the therapy session but should be brought into the therapeutic process in a central way (Blesedell Crepeau & Cohn, Boyt Schell, 2009).

Critique against the occupational therapists concepts of client-centred care, is the difficulty to working along the concept, when there are multiple factors to take into account. The major factors are the occupational therapists intrapersonal and communication skills that achieve effective collaboration with the patient (Blesedell Crepeau & Cohn, Boyt Schell, 2009). Moreover there could be a lack of comfort for the therapists to let the client choose the goals themselves; the reason could be many but stem from values and beliefs about the patient. However there are studies that suggested that client-centred practice associates with improved client satisfaction, increased compliance with medical programs and better functional outcomes (Panelpha, 2008).

**Neurological disorders**

Neurological disorders can lead to various disabilities and result in problems of independence in performing activities of daily life. Neurological disorders can also result in less participating in social relations and contexts, which are of value for the individual. For example patients with neurological disorders can result in a lost ability to grasp objects for activities of daily life, such as eating, drinking, writing and brushing their teeth. They can have difficulties to perform these activities independently and it may also increase the economical and mental load for their families (Bhaskar, 2009).

Occupational therapy studies from India (Kumar Mandal, 2009) show that foremost neuro developmental rehabilitation is practiced. A study by Mokashi (2005) showed that the occupational therapists often use neurophysiological interventions. These are based on neurophysiologic principles of motor control and recovery and that
include Proprioceptive neuromuscular technique (PNF), Bobath’s neurodevelopment approach, Brunstrom’s movement therapy and Rood’s approach. On the other hand occupational therapists in Sweden use a client-centred practice in the combination with clients performance in meaningful activities (Wressle, Eeg-Olofsson, Marcusson & Henriksson, 2002).

As can be seen from above literature review most studies regarding rehabilitation of neurological disorders are from countries in Western Europe and the US. Studies on this subject from developing countries are few. However studies (Kumar Mandal, 2009; Mokashi, 2005) from developing countries have its focus on functional training in rehabilitation, a focus that according to the profession emergence is something used in the beginning of the profession (Blesedell Crepeau & Cohn, Boyt Schell, 2009). Therefore could it be of interest to describe how occupational therapists, in a developing country as India, practice the profession with patient with neurological disorders.

**Purpose**
The purpose of this study was to illuminate how occupational therapists in India describe and enact their work with rehabilitation of patients with neurological disorders.

**Method**
The study has a qualitative approach in order to explore and describe how occupational therapists in India work with rehabilitation of patients with neurological disorders.

**Participants**
The inclusion criteria were occupational therapists and last year master students, working with neurological rehabilitation, and fluent in English. To answer the study’s purpose we did a purposeful sampling, according to Holloway and Wheeler (2010).
Settings
Data collection took place in three private hospitals, of high class in a big city in North India. In these hospitals data was collected in rehabilitation department, which had both outdoor (OPD) and indoor (IPD) patients. The professionals that we interacted with were mostly occupational therapists but also occupational therapists student, physiotherapists, assistive technologist, peer counsellor, wheelchair instructor, patients and their relatives.

Data collection
The study was based on a total sample of 26 interviews and 50 observations, conducted by both authors. Data collection was carried out through semi structured interviews and unstructured non participated observation. The interviews were conducted with 22 occupational therapists and four last years’ master students. The interviews duration was in average 30 minutes. There were 50 unstructured non-participated observations made on the interaction between the occupational therapists and patients, and how the occupational therapists conducted their intervention. The observations duration was approximate one hour and were subjective reflections based on the impression and emotions during the observations. This choice of method was to complement the interviews with the observations and further to have the opportunity to create a deeper understanding of how occupational therapists work.

Procedure
Our person of contact, the director and acting head of physiotherapy at a university introduced us to the specific hospitals, in our host country. The participants were contacted when arriving at the hospitals and a time schedule was made to organize the interviews. To ensure consent for the stay that included interviews and observation, we declared our purpose for the head of rehabilitation’s department. The interview guide was based on the purpose of the study and the observations took place before and after the interviews. The interviews were made in separate rooms with the participants during their workday. The questions was in English based on questions of how occupational therapists do their investigation, planning and structuring of goals, intervention, evaluation and possible over-reporting
The interviews were recorded by MP3 player and transcribed continuously and the observations were typed on laptops everyday.

Data Analysis

Data was analyzed using qualitative content analysis to identify patterns and the underlying meaning in the interview and observations as described by Lundman and Hällgren Granheim (2008). First, meaning units were separately found to consider both authors' interpretation in order to compare and make a conclusion of the interpretation. The codes in each interview and observation were compared to identify similarities and differences and were grouped together into preliminary categories relevant for the study's aim according to Lundman and Hällgren Granheim (2008). The analysis resulted in four categories and nine sub-categories from a total number of 349 meaning units. After further discussion, three categories and no sub categories were found to be the most suitable way of presenting the results. According to Lundman and Hällgren Granheim (2008) to achieve trustworthiness, we shared reflections and discussed findings with each other.

Table 1. Example of meanings units and codes.

<table>
<thead>
<tr>
<th>Meaning units</th>
<th>Condensation</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>There is a lack of evidence to get the latest research in our subjects</td>
<td>Lack in research access</td>
<td>Economical issue</td>
</tr>
<tr>
<td>And then we usually set up some goals for the patient</td>
<td>OT set up goals for the patient</td>
<td>Decides of goals</td>
</tr>
<tr>
<td>We can make the patient independent</td>
<td>OT’s expectation of their responsibility</td>
<td>OT’s responsibility</td>
</tr>
<tr>
<td>We make the goals, like moving on with the balance and upper limb strengths and see how they proceed</td>
<td>OT conduct the goals and then proceed with balance and upper limb</td>
<td>OT control the process and have a functional focus</td>
</tr>
</tbody>
</table>
Research ethical aspects

Qualitative research involves many ethical issues to consider, one of the issues are that the participant can feel pressured to respond to each question and thereby feel nervous and inadequate if they can not answer (Merriam, 2006). The ethical principles followed in this study, was to be coherent during the interview and not put any pressure of the participants if they seem uncomfortable. Also ensure confidentiality and anonymity to the participants. When meeting the participant’s further information was given about the study's purpose and structure, what their involvement would mean and that it was voluntarily to participate and that they could cancel at any time. This was ensured by written consent (Appendix. 2). The participants were also given access to authors' contact information in order to be able to take part of the study's results and ask questions afterwards. The collected data were stored in a secure and confidential manner and all interviews and observations was de-identified and encoded in the according to the guidelines from Vetenskapsrådet (2008).

In our situation, it was also important to take into account ethical guidelines for visiting and working abroad. Our approach was characterized by respect both at work and at leisure for our host country. Further, we clarified that we were not from an aid organization, to prevent those around us who could misunderstand our stay (Utrikesdepartementet, 2004).

Results

The analysis resulted in three categories: Economy and family factors affect the rehabilitation, Client centred practice and Following the OT-process. In all categories there are literal quotes to increase credibility.

Economy and family factors affect the rehabilitation

According to the participants, something that affects their work with patients is largely an economical issue. Rehabilitation is still developing and is lacking in many areas. One aspect is the difference between health care in government hospitals and private hospitals. The participants describes that if a person has economical resources they
will choose a private hospital, because service and resources are more developed than at the government hospitals. Moreover they report that rehabilitation arrangement is a question of money, and that the patient pays for every session. One occupational therapist describes that one of the first questions asked at the hospital is:

“For how long have you thought of being here? How long rehabilitation can you afford?”

Based on what the client answers the occupational therapist begins with the rehabilitation plan.

It seemed that the patients had no right to question the length or number of rehabilitation opportunities when receiving rehabilitation. One patient seemed to sleep during his rehabilitation exercise and some were so tired and exhausted that it looked dangerous to continue the training. The occupational therapists however explained that rehabilitation sessions are planned and paid for in advance, so they make sure that the patients receive training twice a day, one hour per session since this was something the patient paid for. Normally they would not change the time or number of sessions, paid for. Another economical factor was that the participants described that the private hospitals had different departments, where financial resources were controlling whether the patient could choose a standard or high-class department and the differences in the department was mostly about privacy, cleanliness and space.

The patients’ family had a role in the rehabilitation according to the participants. A big part of the rehabilitation was to describe and make the family understand their relative’s disorder and needs. Using both verbal information and writing inputs from the occupational therapist the family gathered the understanding for the rehabilitation. However, the participants described that the patient's family or relatives sometimes perceived rehabilitation to be their task, to take care of the patient when an injury or illness had affected them. They did not always share the occupational therapist’s view of the patient becoming independent through rehabilitation since this could be seen as a sign that the family and the relatives where failing in their care.
Another economical issue, from the participant’s point of view, was that the
participants described that in order to access any published research material that
was from India one had to be a member of All India Occupational Therapist
Association (AIOTA) and that you had to pay to take part of it. The participants
describe that there was a lack of evidence for them, and the problem was that they
did not have access to databases and online journals. Therefore their knowledge
about the professions latest task and evidence was restricted and what was going on
international in research never entered their profession. Yet another economical
issue was that many participants express dissatisfaction over their pay and one of
them said:

“About the pay, I’m not happy with it, because we work as slaves,
cheep labour, that’s it, nothing else”.

Furthermore all participants thought their work was very hectic and they describes
that their days was full of patient sessions and sometimes it was hard to find time for
lunch.

**Client centred practice**
The participants described that their relation to the patient was an important part of
the rehabilitation process. They have to involve the patient’s own thoughts of what
their goal would be, in order to keep the patient motivated. They described this
process as the patients decide about 50 % and the rehabilitation team 50 % of what
goals to reach, otherwise there wouldn’t be a process. However, some of the
participants described their own role in the process as:

“The occupational therapist makes the goals”
and also “And then we usually set up some goals for the patient”.

The participants describes that the goals is based on the patients disabilities and
observation showed that to reach the goals they use functional training. Some of the
participants described that the goal setting was something the whole team did
together. The team; the occupational therapist, physiotherapist, social worker and
peer counsellor, meet about once a week to discuss the patients potential to achieve in the rehabilitation process.

During the interaction between the occupational therapist and the patient, the occupational therapist often received several private telephone calls on their cell phone during patient interviews and interventions. The patients never seemed to complain about this and showed the occupational therapists respect in silence. Another part of how the participant’s described their work with rehabilitation was their responsibilities to make the patient independent in different activities. One participant described his work like this:

“We can make the patient independent in every day activities, this is our main goal”.

However, the occupational therapists only performed functional training. The training took place in a big area with several patients training at the same time, which created a load and disturbing environment. Several of the patients had their relatives with them, some of the patient was lying down training and some of them were making cognitions test. One patient who was conducting a cognition test looked scared and apologized several times for his bad cognition. The occupational therapists continue to ask questions that seemed too difficult to understand for the patient and he failed with the entire task.

**Following the OT- process**

The participants in the study described that the rehabilitation process in India follows a regular occupational therapy process. The patient begins at the hospital with a meeting with the doctor. The doctors make a report and complete the patients’ personal data, past history and medical history to forward to the occupational therapists. It is almost always the doctor that recommends the patient to go for rehabilitation and to get occupational therapy. The participant’s describe that they start with an evaluation or interview to find out some about the patient’s considerations and their condition. After they move on with the assessments and depending on the patient’s needs and the therapist’s skills they choose instrument that evaluate their functional mobility and ADL capacity. Some of the participants
describe that they find out the patients problems from the doctors’ report instead of interviewing the patients. The participants describe that they moved on to ADL-training at the rehabilitation department. However, during the observations in the rehabilitation department no ADL-training was ever observed apart from a board with a shirt with buttons to practice buttoning up and a sewn zipper to practice to close.

The participants described that they often started with testing the strength of the upper limb and then moved on with mobility, balance strengths and ADL activities like self-care. According to this description they illustrate their focus with the following statement:

“Often we see their functional status, like balance and ADL.”

Some participants also described that there focus as occupational therapists were on the upper limb and that the physiotherapists focus on the lower limb. In many of the sessions there were no difference in what the occupational therapist or physiotherapist did with the patient’s. Most patients in the rehabilitation department were passive in their interventions with the occupational therapist. They were placed in beds or bunk beds and the therapists stood or sat beside them and made the movement in the patients’ joints. The patient was totally passive in the movement and did not try to participate actively. Much of the movements resembled contracture prophylaxis. Some patient were placed on a Bobath ball and pushed up and down. Moreover many relatives participate in the interventions and supported the patient’s safety. The participants described that teamwork was an important aspect for the rehabilitation. According to that, they describe the professionals as cooperative and if there was any problem they easily gave each other advice. The most common teamwork was between the occupational therapists and physiotherapist. If needed there was also a wheelchair instructor that could join the team. He teaches advanced wheelchair skills and also practises patients in different wheelchair sports. On the other hand, some of the participants described that it was hard to communicate between the professionals. The participants describe that in the end of the process often characterized by achievement to evaluate the goals but also to prepare them for finishing the rehabilitation. For example the participants describe home modification or counselling. Moreover they describe that if the patient lives
near, they go home to the patient and if they lives far away the participants gives advice modification for example installation of ramp. According to this the patient also gets evaluated in what they called home program, there they include the patients need for example car modification or self-care areas that needs to get evaluated.

**Discussion**

**Results discussion**

The purpose of this study was to illuminate how occupational therapists in India describe and enact in their work with rehabilitation of patients with neurological disorders.

According to Fischer (2009) intervention process (OTIPM) occupational therapy has a unique focus on occupation. When occupational therapists talks about “function” it comes from the perspective that function primarily relates to a person’s ability to perform activities that they want or need perform, this in order to become more independent and able to participate in social activities. The results from our study show that training in an activity is something that the occupational therapists described that they include in their rehabilitation. However, the rehabilitation sessions were only in functional and passive training, when the occupational therapists stretch and bend the patient’s joints. This was something that the patient seemed comfortable with and satisfied.

Another part in the rehabilitation is the client- centred work (Panelpha, 2008). Wilcock (2006) describes how to include the patient in the process and that the patient is the expert in their situation and therefore achieving self- determination in their own life. To collaborate with the patient in the rehabilitation process includes to make the patient participate in the decision-making and also to construct the goals. The result indicated that the participant's description of how to set goals for the rehabilitation interventions did not always come from collaboration with the client. According to a top-down approach the goals should be set based on the results from different evaluations of the patient’s performance of desired activities (Fischer, 2009; Kielhofner, 2008). Moreover the two-way communication is underlying the
collaboration and for occupational therapists it is important to construct a climate with mutual trust and respect (Fischer & Nyman, 2007). Difficulties in using the client-centred concept is when the therapists let his or her values and beliefs about the patient and their own role, affect the comfort in the decision making, which could create a problem in letting the patient make the decision (Panelpha, 2008). These findings are in line with our result when the participants describe their responsibility to set the goal and plan for the process. According to the participants the patient’s economy decides the length and goals for the rehabilitation and for that reason the patients recovering needs is never the base for the rehabilitation plan.

Similarities in the client-centred and family-centred care are the focus on collaboration between the patient and the family to form coping strategies to manage the situation (Panelpha, 2008). Our result indicate that the participants cooperative with the patients family. The participant’s view of whether the patient is becoming independent through rehabilitation is not always in line with the patient’s family opinion, since this could be seen as a sign that the family has failed in their care. Although the family centred approach includes the family’s decision but also involve the knowledge of how the impact of the patient’s health affects the family members (Blesedell Crepeau & Cohn, Boyt Schell, 2009). According to the participants the family could be a barrier for the patient’s progression in the rehabilitation process.

The human is an autonomous being with individual basic components which include volition, habituation, performance capacity, that result in activity identity (Kielhofner, 2008) To avoid ethical dilemmas the occupational therapist respect the right of all people to make choice and decisions based on their own individual values and beliefs (Beuchamp & Childress, 2001). Previous study describes that it is common with ethical dilemmas for occupational therapists in their daily work, this mostly occurs in situations where there are many persons involved and everyone involved has their own opinion of what is best for the patient. Occupational therapists can reduce ethical dilemmas through acting as supervisors, supporting the client in the new environment to make the client independent and able to make his or her decisions (Kassberg & Skär, 2008). Our results show several statements where ethical dilemmas arise. The patient’s economy affects the length of the rehabilitation, where decisions depend on their economic situation. Because of the advanced
payment, the rehabilitation session was never formed after the individual activity identity. Another point is the non-existing collaboration in goal making, where the occupational therapist decides the goals without the patient’s choice and decisions. To achieve effective collaboration with the patient the occupational therapists need good intrapersonal and communication skills (Blesedell Crepeau & Cohn, Boyt Schell, 2009). During the observations of sessions, lack of respect was shown when private cell phones where answered by the occupational therapists. Other factors that disturbed the patients were the loud and disturbing environment in the big training department, particularly for patients doing cognition test, when the participants continue the test, without considering the patient performance capacity.

Daily meaningful activities are defined as activities that an individual finds important and enjoyable, ranging from simple satisfaction from small daily rituals to the intense pleasure people feel, in pursuing their driving passions (Kielhofner, 2008). Although observations show that all training was passive functional training, which not includes either daily rituals or other activities of passion. Use of meaningful activity in intervention designed to achieve disability or functional outcomes, promote health, prevent injury or disability and develop, improve, sustain, or restore the highest possible of independence (Legg & Drummond, Langhorne, 2006). Results showed that the participants talked about that it is their responsibility to make the patient independence in different activities; this is however something inconsistent from observation where training was of functional approach. According to the participants their responsibilities is to make the patient independent in different activities. This is inconsistent from the observation there gross motor function training was combined with the statement that the occupational therapists is the one who make them independence. The results indicate that the reason for the functional training and the non-activity training might be the patient’s view of rehabilitation - occupational therapy is something you pay far and receive and not something you do yourself.

The profession has developed from having mechanistic functional focus toward a holistic and activity focus. The holistic perspective is grounded on research that shows activities positive affect on health (Blesedelle Crepeau & Cohn, Boyt Schell, 2009). This focus was never shown either in the interviews or observations, and could be explained by the limitation of evidence. Their lack of evidence is explained
by the participants as an economical issue and reason. Knowledge about the profession’s latest task and evidence is therefore restricted. These results are also in line with earlier findings, Kumar Mandal (2009) and Mokashis (2005) articles, were occupational therapists using neurological instruments from sources dating back to the years 1954-1990. Working as an occupational therapist assumes that occupation is something practitioners need to base their work on. Further to make the patient understand the occupations benefits in the rehabilitation (Blesedell Crepeau & Cohn, Boyt Schell, 2009).

Occupational therapy view human beings as by nature active and adaptive and the developing depend on activity and action (Förbundets Sveriges Arbetsterapeuter, 2005). Activity gives life meaning, organize behaviour and have a therapeutic value (Blesedell Crepeau & Cohn, Boyt Schell, 2009). This line of reasoning, by having choice, control and ability to engage in everyday life occupations consider to be strong influenced on health and quality of life (Law, Steinweinder & Leclair, 1998; Christiansen, Backman, Little & Nguyen, 1999; Fischer, 2006). Our result of this study leads us to believe that because of economic reasons and their circumstances as a developing country the participants have not the same conditions to get the latest research and evidence among the profession. However, their way of working perceived effective with their circumstances and patient’s expectations was in compliance with the care and rehabilitation they receive.

**Method discussion**

Through the interview, the participants described their situation to us from their own perspective and in their own words. The advantages of the semi structured interview were that we could follow up interesting thoughts and get more out of the interview. The reason that we chose to collected data though interviews together with the observation was mainly to complement the interviews. We believe this is necessary since "reality" does not always reveal itself in interviews.

The interview guide had an open question approach, with the aim to get narrative responses and the inside perspective from the participants experiences. To increase credibility, unstructured non-participated observation was also done and made an important part of our result. The use of the interview guide was a strategy used to
improve trustworthiness because it allowed follow up questions and that the participants could read the questions in front of them. If a misunderstanding of the questions arose there was a chance to correct this. Since that the interviews was not carried out during the same day, it might impact the participants who could exchange ideas and opinions about issues and therefore rehearse similar answers. Because of the rare situation of interviews, our stay could perceive as an investigation and the participants perhaps felt nervous and concern for responding wrong. The interview situation could also perceive as unpleasant because of two interviewers and one participant. Although this was a good alternative to capture a good amount of data and the interviews became similar and proceeded well. Further strengths of being two authors were that the data has analysed first separately and then together which also increase a higher credibility. According to Sandin, Grahn and Kronvall (2004) another important factor during our stay was that we, from the same culture, could share our experiences with each other and thus develop both our analysis of the study and our coping strategies to endure the new culture.

The head of the rehabilitation department values and beliefs, of our stay could also affect the participant’s attitudes to participate. Furthermore the participant’s attitudes and ability to work under the observations interpret as good and we could make our observations without disturbing their interaction with the patients. The big department enable observations of many patients at the same time, therefore there was not made any presentation of us, to each patient. This environment did not include any ethical dilemmas in our situation, though observations was done from everyone; patient, relatives, professions. The context was perceived permissive for observations.

However, according to Denzin and Lincon (1994) the results of our study cannot be generalized; instead, the results can be derived in similar situations if these are modified to comply with the context. It would be interesting to investigate occupational therapists working in government hospitals in India or private hospitals in other development countries.

The study’s ethical aspect has followed and all the participants have been coded in the transcriptions of the interview and also in the observations. Before started the
interview we explained the aim of the study and consent was created. Because of the aim of the study and the fact that we did not interviewed any patients there was not any conditions of an ethical review. At last, we consider more benefits then risks of the study, when the meetings with the participants opened for exchanges and discussions.

**Conclusion**

The result shows that the participants work with passive functional training as method in rehabilitation of patients with neurological disorders. This might depend on economic reasons and their circumstances as a developing country and the participants have not the same conditions to get the latest research and evidence among the profession. However, their way of working seemed perceived effective with their circumstances and patient’s expectations was in compliance with the care and rehabilitation they receive. Furthermore, the results of our study cannot be generalized, for future research it would be interesting to investigate occupational therapists working in government hospitals in India or private hospitals in other development countries. Implications for clinical practice may be a better understanding of how the participants work in India, curiosity and further critical thinking about the profession and the value of evidence.
References


Appendix 1

Interview Guide

How does a normal working day look like?
- Place of work
- Organisation/ healthcare in India?
- Patient
- Professionals

Can you describe your career?
- Before - Education – After
- Other place of work
- Why Occupational Therapist?

How can a rehabilitation process look like?

How much does the patient involves in the planning/setup?

Investigation
- How can a meeting with a patient look like?
- How long is it? Use any instruments for interview?
- Use scientific knowledge about illness, injury?

Objectives/ Goals
- How do you and the patient construct goals for rehabilitation process?

Intervention
- Time
- Therapy focus? Bobath?

Evaluation
- Time
Request for participation in our Bachelor thesis work

The purpose of this study is to explore and describe how occupational therapists in India work with the rehabilitation process. We are extremely grateful for your participation in our study and data will only be used for Bachelor thesis work. Data will be collected through interviews, it will be kept confidential and anonymity. All respondents will be encoded and individual responses will not be reported.

Participation in this study is voluntary and you may at any time during the study cancel your participation.

Thanks in advance
Jannice Meyer & Rebecca Nilsson
Occupational Therapist – Students at Luleå University of Technology

Name, Date