



**MEDICINSKA FAKULTETEN**

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Division of occupational therapy and gerontology

**“Weighing my options”**  
**Clients experience of occupational therapy in obesity**  
**rehabilitation**

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**B.Sc. Essay**

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Abstract

Obesity is rising at an alarming rate. The aim of this study was to ask clients in obesity rehabilitation how they experience the role of occupational therapy in the program. A focus group was used and the obesity rehabilitation at Reykjalundur Rehabilitation was chosen as a scene for this study. It is a group program and clients are expected to view their opinions during the diverse sessions of the rehabilitation. The criteria for entering the focus group were participation in occupational therapy as both in- and out-patient. A semi-structured guide was formed using the outlines of the program. A content analysis was made and the recurring themes were noted. The clients had little knowledge of occupational therapy before entering the program. At the out-patient clinic, they learned how to structure their activities. As in-patients they learned about prioritizing meaningful activities and goal setting. The use of arts/crafts and relaxation in the occupational therapy was a pleasant experience. After five weeks as in-patients, the members of the focus group stated the need for support in maintaining structure in daily activities.

Keywords: obesity, occupational therapy, clients, experience, rehabilitation, qualitative, focus group

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# 1. Introduction.

## 1.1. The obesity epidemic

Obesity is rising at an alarming rate and roughly 135 million European Union (EU) citizens are affected and around 70 million in those countries seeking to join the EU. The estimated cost of obesity is up to 8% of health budgets and obesity can lead to individual illnesses, disability and early mortality, followed by increased costs to employers, tax payers and society as a whole. A growing proportion of adults within the EU and neighboring countries are in need of more effective therapeutic management to control their obesity. The International Obesity Task Force (IOTF) concluded in September 2002, that the EU should include research on obesity in the Framework Program on Public Health 2003-2008. Physical inactivity alone does not explain the epidemic (EASO, 2002).

Much effort has been put into linking the prevalence of obesity to our genes and over 400 genes have been identified as role players in weight regulation (Astrup, A., Hill, J., & Rössner, S, 2004). Still, that has not led to a decrease in the prevalence of obesity. Studies should focus more on which components in our behavior and our environment makes us gain weight. More effort should be put into teaching people to modify their current environment and change their behavior.

According to IOTF (2002), obesity is defined as a state where the body-mass-index (BMI) is above 30 kg/m<sup>2</sup>. According to self-reported BMI-data, the prevalence of obesity is increasing in Sweden. Studies show that roughly 10% of women and 10% of men in Sweden were obese in 2002/2003. Also of consideration is the well-documented fact, that when giving a self-reported BMI, a person tends to underestimate her weight and the value of underestimation increases with increasing weight (Mårild, S., Nevious, M., & Rasmussen, F, 2007).

## 1.2. The frame of reference.

Treatments for obesity within the health care system mainly consist of three components: gastric-bypass-surgery, medication or cognitive behavior therapy (Stahre, 2002). Lifestyle interventions are an important predictor of success in maintaining the weight loss, regardless of the method used to loose weight (Alger-Mayer, S., Polimeni, J., & Malone, M., 2008).

Studies of obesity show, that weight loss is difficult to achieve, but maintaining the weight loss is even harder. To maintain weight loss, the treatment for obesity must focus on variable components in our lives; physical, psychological and psychosocial. Weight maintenance is associated with internal motivation, social support, self-efficacy and better coping. For successful weight maintenance and a regular meal rhythm, way of life must be stable and without stress. The successful 'maintainer' can also rely on the support of his social context (Elfhag & Rössner, 2005).

The issue of social context is especially interesting when discussing obesity. Studies have shown that obese persons receive continually negative comments about their weight from family and friends. This sometimes results in less participation in meaningful occupations. Meaningful occupations are all the activities in our lives that are an integrated part of our occupational continuity. Meaningful occupations affect our physical- and mental health, along with our life order and routine. They affect our roles and our relationships (Mandel, D., Jackson, J., Zemke R., Nelson, L., & Clark, F., 1999). Obese people avoid getting involved in occupations that have meaning for them because of the insults about their weight and appearance. Sometimes they even 'outlaw' themselves from society (Singelhurst, H., Corr, S., Griffiths, S., & Beaulieu, K., 2007). This could, in severe cases, lead to a persons occupational deprivation or alienation, to a similar amount of those who experience incarceration. In her study on prisoners, Whiteford (1997) found out that the inmates had not only experienced occupational deprivation in jail; some of them had lived their whole lives in deprivation from access to meaningful activities, due to number of complex variables. This could also be the case where socioeconomic and political circumstances contribute to overweight. Obesity can be the result of a disparity in relation to environmental and social health issues. Socioeconomic status is relevant when studying the reasons for obesity. Studies made in USA have shown that access to and quality of preventive care, cultural beliefs and low income contribute to a decline in health status and an increase in the prevalence of obesity (Blanchard, 2009).

Forhan (2008) studied the impact of obesity on education, employment and recreation. She argued that an obese person must experience occupational deprivation, alienation, marginalization and imbalance. Emphasizing solely on eating less and exercising more on a daily basis, creates an imbalance and disrupts the routine of daily occupations; especially when that person is also a family member, an employee and/or a social being. This must,

according to Forhan, be taken into consideration, as it would be if that person was struggling with some kind of disability. Simply enhancing increased participation in daily activities can lead to more physical activity in daily routines and thereby increase endurance and/or burning fat. Forhan says: *“It is not necessary for occupational therapists do develop new skills to meet the needs of people with obesity. Rather, occupational therapists need to be informed about obesity, obesity treatment ...and advocate for the application of occupational therapy in the area of obesity prevention and treatment”* (2008:16).

According to the American Occupational Therapy Association (Clark, F., Reingold, F., & Salles-Jordan, K., 2007) occupational therapists, with their expertise in client-centered therapy and the focus on the clients environment, could play an important role in battling the obesity-epidemic. By building strategies and planning everyday life, occupational therapists can help their clients to form new habits that include activities that promote health and empower changes. Empowerment is a concept that focuses on strategies that enhance the individuals believes in his performance capacity (Medin & Alexandersson, 2000). It motivates him to make decisions about his own life and at the same time, take responsibility for it

Occupations can create new visions of self and prevent imbalance. The Lifestyle®Redesign Program has been used as a framework for its own Weight Management Program, it's core being the human necessity for occupation (Mandel et al., 1999). The key aspects of the program include a four month lifestyle modification program, which organizes daily habits and routines to develop a balance of healthy habits, including physical activity, leisure and meaningful activities. It focuses on the management of stress and its relationship to diet and physical activities. As the program in Reykjalundur, it is linked to gastric-bypass surgeries, and offers prospective clients help to lose enough weight for improved surgical outcomes (Lifestyle®Redesing Weight Loss Management Program, 2009).

The Model of Human Occupation (MOHO) is one of several conceptual practice models in occupational therapy, a set of theories, developed for practice (Kielhofner, 2002). MOHO addresses three specific phenomena, all of which are important when an occupational therapist is assisting a client in lifestyle changes. The first concern of MOHO is to understand what motivates people and makes them choose the activities that fill their life. This component of MOHO is called volition. The second concern of MOHO is the recurrence in

daily activities, how people behave in a given way day after day. This is the component of habituation. The third component of MOHO is the range of capacity for performance when people involve in activities. Occupational performance is subject to physical and mental abilities. Also of interest to performance capacity is the concept of the lived body. It refers to experiencing the world through a particular body and is therefore very intriguing when linked to obesity. These components are all intertwined, where one affects the other. They are different aspects of every human. Within volition, there is personal causation, values and interests. Within habituation, we have habits and roles, and within performance capacity, we have the ability to perform activities, subject to experience and environment, based on our objective physical and mental capacities. All of the above can be linked to the ongoing process of lifestyle changes, required to loose and maintain weight. By using MOHO as a frame of reference, an occupational therapist can strengthen his role in a team of practitioners, treating obesity. By educating the clients on these components and how they affect lifestyle, involvement in health promoting activities can be motivated, patterned and performed.

### **1.3. Obesity-rehabilitation**

The obesity-rehabilitation in Reykjalundur was initially a five week in-patient program. Obese patients, who were preparing for gastric-bypass-surgery were among the clients. There had been good results from these surgeries at Landspítali University Hospital. To prepare more patients for operations, cooperation with Reykjalundur was asked for. In 2006 the Ministry of Health legislated increased funding due to the programs extended waiting list, which counted about 400 people. Interestingly enough, not all were preparing for gastric-bypass operation; an increased number wanted to change their lifestyle and loose weight without having the surgery. In the fall of 2006, a full time senior occupational therapist was recruited to the program, alongside physician, two nurses, social worker, psychologist, nutritionist and a physical therapist. Interdisciplinary programs are well established in Reykjalundur and were therefore used as a conceptual framework when forming the team of practitioners for this department.

The program takes two to three years, and clients are referred to Reykjalundur by their general physician. After almost one year on the waiting list, clients are first interviewed by the physician in the obesity team. The first part of the treatment takes place in an out-patient clinic, where clients get support and preparation for their life-style changes they embark

upon. The criteria for in-patient treatment are that in three to six months, the client needs to lose at least 5% of his weight at the time he first meets the team physician. The clients can enhance the course of action by losing these 5% on their own or with assistance from e.g. their local health clinic. They can then enter the program without much consultation from the obesity-team in beforehand. Motivation is considered greater if the client has begun preparation in advance and already lost some weight, as lifestyle interventions and behavioral changes are an important predictor of long term success (Alger-Mayer et al., 2008). The in-patient program is a five-week period and then about three months later, a three-week period. The program is a group program, where each group counts six to eight clients, who spend three days a week together in working out and attending therapy sessions held by members of the obesity team, e.g. lectures and meal preparation. The group usually consists of four to six female and one to two male. In 2008, 1396 females and 384 males attended the out-patient clinic to meet with the obesity team (Reykjalundur, 2009).

The role of the occupational therapist (OT) is to advise the client on shopping, preparing meals and teaching him relaxation. In addition the OT gives five sessions concerning the ability to handle life-stress and creating a balanced lifestyle, alongside coping strategies, internal motivation, self-efficacy, assuming responsibility in life and goal setting. These sessions involve various assignments to be filled out by the client, e.g. 'the wheel of occupation' (Reykjalundur, 2009), which is a journal of activities during 24 hours on a given day of the week.

Other activities, lead by various members of the team are physical activity, lead by the physical therapist, seminars with physicians, group sessions with nurses, seminars lead by the nutritionist and group sessions lead by the social worker. After the first five weeks, clients can invite their family members to join in for a family meeting.

Clients can meet with any member of the team for a personal consultation if desired, and this applies both for the in-patient program and for the whole two-year period. After the first five weeks the clients may or may not undergo gastric-bypass-surgery. Three to four months later, the second part of the in-patient program starts. The OT has then three sessions concerning balance in activities of daily living, relaxation and personal consultation if needed. During the in-patient programs the clients have access to the OT at the crafts-room twice a week and can participate in the relaxation sessions, offered daily by the department of occupational



therapy. After the second period, the clients receive a card with seven scheduled appointments, every three months, which include a one day-version of the in-patient program; group-sessions, physical activity and personal consultation.

For the last ten years the researcher has worked as an occupational therapist (OT) in various rehabilitation fields and in 2006-2008 as a senior OT in an interdisciplinary obesity team at Reykjalundur Rehabilitation in Iceland. The aim of this study is to find out how the clients perceive the role of occupational therapy in the program. Their experience is especially interesting because the use of occupational therapy in treating obesity is not common or well known in Scandinavia or the EU. While occupational therapy is quite well established in treating for obesity in the USA and Canada, no records were found when seeking on those keywords in the Scandinavian Journal of Occupational Therapy.

As the team in Reykjalundur is interdisciplinary, it is not the researchers' intent to compare the occupational therapy to other parts of the program. The aim is to gather information on the clients' experience of occupational therapy and discuss that in a given frame of reference and the Model of Human Occupation.

## 2. Aim of this study.

The aim of this study was to gather information on how clients in obesity rehabilitation at Reykjalundur experience the role of occupational therapy in the program. Statements from USA and Canada indicate that occupational therapy is useful in battling the obesity epidemic. Given the frame of reference, it is interesting to hear the client point of view and learn what they know about occupational therapy. How they perceive the use of planning, goal-setting and prioritizing in this kind of program is important when forming the conceptual framework for treating obesity. The use of arts and crafts or relaxation when embarking on life-style changes may not seem of importance so that was included in the interview-guide. The question of support from their peers, their social context and the community is also of interest.

### 3. Method

Since this study was on the clients' perception and opinion on the role of occupational therapy in an interdisciplinary program, qualitative methods were considered appropriate. Qualitative research often uses inductive reasoning, and instead of testing theories, they examine the empirical world and develop a theory of their own (Esterberg, 2002). Information was gathered by using a focus group, but they are often used to evaluate programs. Public health researchers can obtain valuable opinions or attitudes from people by interviewing a focus group on health related matters, rather than asking them about their actual behavior. A focus group is also useful to understand group processes (Esterberg, 2002). The obesity rehabilitation at Reykjalundur was chosen as a scene for this study. It is a group program and clients are expected to view their opinions during the diverse sessions of the rehabilitation. Since the researcher had worked for two years in the program and was familiar with the pros and cons of group-processes, pre-interviewing was not seen as necessary. Applications were made to Várdvetenskapliga Etiska Nämnden and the Icelandic Board of Ethics in Science and received full approval. The chief-physician and team physician at Reykjalundur granted their approval, as did the chief-occupational therapist, who acted as an observant during the meeting with the focus group.

#### **3.1. Selecting participants.**

The criterion for becoming a member in the focus group was participation in occupational therapy during both in- and out-patient sessions. The current occupational therapist in the obesity team contacted participants via telefon, based on their attendance in occupational therapy during their in- and out-patient sessions. In order to get as much variety of opinions, a group of both sexes and all ages were contacted. It was also seen as necessary that members of the focus group had attended the program within the last year. The occupational therapist contacted ten people but four were unable to attend the meeting at Reykjalundur. According to Wibeck (2000) it is good to have four to six participants in a focus group. If more than six participants are present, there is the risk of sub-groups forming. It can also affect the quality of analyzing the tape.

The focus group consisted of 6 people, 4 women and two men, aged 22-62. As a comparison to common gender differences in the program, men were about 1/4 of the team out-patient clients in 2008 (Reykjalundur, 2009). All of them had undergone the five week in-patient

program and had contact with the occupational therapist at the out-patient clinic, before and after these five weeks. They were all employed and the youngest member was also in school. None of them had a university degree, but all except the youngest had vocational training within their branch of employment; a teacher, a printer, a secretary, one within the food-industry and one in trades. Participating in the focus group was free of choice and the members were informed that they could leave the group at any time without explanation, and that would not affect their further participation in the program. The issue of confidence was also raised and the participants were reminded of their bound to secrecy, as is also done in the program.

### **3.2. Preparation**

A semi-structured guide was formed using the outlines of the program (Appendix 1). At first, twenty questions were raised on the clients experience on occupational therapy in the program. They were then narrowed down to ten by focusing on the out-patient clinic and the first five weeks as an in-patient. Then, five themes were chosen for closer examination. By using a semi-structured interview guide, the researcher could introduce the purpose of the focus group, keep the questions open and then use follow-up questions to clarify responses or to obtain additional information. The follow-up questions were kept neutral in order to not lead the client on to a specific answer (DePoy & Gitlin, 1994/1999) and the participants reminded that there are no right or wrong answers in this kind of research (Esterberg, 2002).

### **3.3. Procedure.**

The meeting took place at Reykjalundur, in a quiet room on the 2<sup>nd</sup> floor, formerly unknown to the clients. The chief-occupational therapist acted as an observant, which was a demand from the Icelandic Board of Ethics in Science. She is educated within management guidance and tutelage. Efforts were made to improve the quality of sound in the room by setting the table with a (green) table-cloth. When the participants arrived at the meeting they all signed an agreement and gave their permission for using the focus group results for this qualitative research. The group was again informed on the purpose of their participation and the researchers' interest in their perception and opinions of the occupational therapy at Reykjalundur.

The meeting with the focus group was taped and the observant took notes on seating and group dynamics. The first playback was right after the meeting to ensure that it had been

taped successfully; another playback was on the way home. Since transcription was not possible immediately, due to lack of appropriate facility in Iceland, the researcher frequently listened to the interview in the following days, trying to “immerse” himself with it (Esterberg, 2002). When arriving in Lund, a week later, the interview was transcribed and coded.

### **3.4. Data analysis.**

The aim of the analysis was to find the meaning of what was being said, by making a content analysis (Wibeck, 2000). After printing out the transcription, the data was analyzed, using open coding to sort what was being said, into different themes. Instead of using initial bouts of coding, the process of open coding was used to reveal potential meanings. This was done by using markers in different colors. With open coding, the goal is to see what was in the data, not what ought to be there (Esterberg, 2002). Recurring themes were noted for further analysis, also called focused coding. The data is then analyzed again, and now based on these recurring themes. This was repeated a few times, while looking for patterns, comparing statements (e.g. on the out-patient clinic), and holding them against one another. The will to see alternative aspects which rose from the discussions in the focus group is an important factor, but sometimes no opinions are raised on a given matter or the group does not agree on it (Wibeck, 2000). Notes from the observant were helpful here; the men were more quiet than the women, as will be discussed in the result chapter. A short conclusion was made on every theme, to gain perspective and overview for further analysis and discussion. The themes and interview guide were then compared and the results are presented in coherence to the interview guide, to give the study a congruity.

## 4. Results

This chapter will discuss the main findings from the focus group, which are divided into five themes: little knowledge of occupational therapy before entering the program; the importance of structuring activities when embarking on lifestyle changes; achieved insight in goal-setting and prioritizing meaningful activities; the pleasant experience of using arts/crafts and relaxation in the rehabilitation process; and at last, the clients huge need for support and direction during out-patient sessions. The themes will be discussed in this order.

### 4.1. Knowledge on occupational therapy

Only two members of the focus-group had experience with occupational therapy before. They described the sessions at the out-patient clinic as “*very different from massive occupational therapy like arts and crafts or ergonomics*”, and one of them stated “*I thought she was going to teach me how to make baskets*”. One lady was working in the health sector and saw the occupational therapist (OT) as someone who brought helpful aids like rollers or splinters. The meetings with the OT at the out-patient clinic were described as helpful and useful preparation to the program. None of the members knew in beforehand that there would be an OT in the team. They stated that they would never have asked to meet with an OT, even though they had one in near vicinity, like at their local health clinic. They did not remember if the OT in the program had used any kind of form for them to fill out, but the OT there uses MOHO’s Occupational Self Assessment with every client (Reykjalundur, 2009).

### 4.2. Structuring activities at the out-patient clinic.

At the out-patient clinic, the clients came once a month or more often if they desired, to meet with their OT. Their goal was, as can be expected from the admission requirements, to lose 5% of their weight. A very well known ‘tool’ and feared by clients at the out-patient clinic is the food journal. It is handed to them at their first meeting with the team physician and they are supposed to measure their daily amounts of calories. The members of the focus group all discussed how the OT helped them see this kind of registration as something positive. They learned that it was not just about the food they ate, but also about their use of time in various activities, when and how they ate and the surroundings during their meals. They also found the registration helpful in other ways, like “*making me more effective in a positive way*”, as one client said, and finding out that they did indeed have lots of time for exercise, if they only made plans for it. They also found the journal helpful in making room for meaningful

activities and something they wanted to do:”*just for me...more time for me*”. Another important note was “*it helped me see how chaotic my life was...she really made me see the essence*”. The members of the focus group stayed at the out-patient clinic for 4-12 months, before reaching the desired weight loss of 5%.

### **4.3. Learning to set goals and prioritize meaningful activities.**

The focus-group discussed how their lifestyle, during and after the five weeks as an in-patient, went from “*floating around in the world with lots of unnecessary activities and detours*”, as one client said, to setting goals and priorities, as it was done in occupational therapy. They discussed how they initially were reluctant to write down their goals, which was one of the assignments, because they were afraid of failure. They described how surprised they were when they succeeded. The most memorable phrase from the assignments was “*realistic goals*”, which underlines the importance of planning everyday life. They claimed that they would have wanted more of this kind of teaching and guidance, and one female client said that “*I think everyone should get a private lesson from his very own occupational therapist*”. This particular client was using a daily schedule to help her with activities of her everyday life. The clients described how they no longer felt guilty with prioritizing, and only doing things for pleasure or to treat themselves. Their focus went from just being, to wellbeing and taking control of the situation: “*I am less concerned about comments from old aunties...I prepare myself before I meet them*”. Others also described the empowerment they felt within, when learning about internal motivation and self-efficacy in occupational therapy.

One female client described how she, during the occupational therapy sessions, always heard something new that interested her: “*I never sat there and thought I have heard it all before*”. They emphasized their need for follow-up on the assignments, as one said: “*I found my wheel of occupation three months later...completely empty*”.

When asked of the role of shopping and preparing food, they found it helpful to induce new habits and routines. By going shopping with the OT and carefully examining the store, the possibilities of buying new kinds of vegetables, going through nutritional information, they learned a new way of shopping. One said: “*shopping now takes so much longer... (laughs)...and I always think more about why I am buying this and how I am going to use it*”. Through preparing a meal together they experienced the joy of the social context, “*talking,*

*laughing, getting new ideas”, and “not throwing yourself at the food, but drinking a nice glass of water”*. During the meal-preparation they also found, that trying out new recipes at Reykjalundur, practicing there, made it easier to introduce the same recipe at home *“I am always making the same dishes over and over at home, and now this course is included in my repertoire...hopefully something unhealthy fell out instead”*. The group all agreed in that there should be more cooking and shopping in the program.

During the 5 weeks as an in-patient, three of six members in the group were also working, that is, they went to work the two days of the week there was no program. They described it as a struggle, *“I was going to work in the mornings as well, but it was to stressful”*. The others used the facilities at Reykjalundur every day and would not have had it any other way. *“this program is a full time job”, “I only went home on the weekends”* said a woman who lived 60 km away and was therefore entitled to overnight accommodation at Reykjalundur.

#### **4.4. The positive experience of crafts and relaxation.**

The Reykjalundur obesity program does not include guidance in art and crafts formally, but the OT offers guidance in those fields for clients twice a week. Three members of the focus group came regularly to arts and crafts. The two men never attended those sessions, but one of them attended aquarelle painting classes adjacent to the occupational therapy, as an extra-curriculum activity. The youngest member of the group chose to play badminton instead. The three women described the occupational therapy arts and crafts as a peaceful place, where they were allowed to forget about everything else, *“switch gears”* and *“do something with my hands”*. They also enjoyed the company of their OT and their fellow rehabilitants in a different kind of setting from the other sessions. When asked if this should be included in the program, all six were positive towards it and saw it as a chance to lessen the burden of physical exercise. The relaxation at noon is an open invitation for all clients in Reykjalundur and is led by the occupational therapy. Four members of the focus group attended regularly. They found it soothing and it also gave them an opportunity to *“change the tune”* and *“forget about everything else”*. One woman went to a course in Rope-Yoga after her in-patient period, because she found the use of relaxation beneficial for her health. Others did find these sessions helpful and tried to evoke the same feelings when sitting down at home after work.

#### **4.5. The ongoing need for support**

All members of the group described their continuing need for support. After the five weeks of being an in-patient, they felt a little lost and alone. Only two of them had booked an appointment with their OT shortly afterwards. The others used the support of their peers, which they had attended the program with. Interestingly, the male clients had lost contact with their peers much sooner than the female clients and were more vulnerable to the demands of their family members. While the women described how they were more in-charge at home and goal-oriented, the men felt powerless towards their surroundings. To describe this one male client said: *“I am on my own with the beans and sprouts, while she is having pork chops”*. The two male clients had also stopped coming to the planned ‘come-backs’ whereas the female clients always made an effort to attend and spoke of the possibility to visit the out-patient clinic. The men had not sought support offered outside Reykjalundur, other than attending one Overeaters Anonymos meeting, which was a disappointment to them. The women sought support from various settings, e.g. from the local health clinic, from a physical therapist, attended yoga-classes, or from someone in their surroundings who also had been through the program at another time.

The distance from Reykjalundur to the clients homes was also mentioned. As the rehabilitation center lies outside the capital, it affects the cost of getting there. The clients admitted that it hindered them in making an appointment at the out-patient clinic or using the facilities at Reykjalundur outside the program.



## 5. Discussion.

In this chapter I will first discuss the method of using a focus group. I will then move on to discussing the results and link them to the background of the study. Possible bias and ethics in question will also be mentioned, and a discussion on the validity and reliability of the study.

### 5.1. Discussion of methods

Only clients who met the criteria for the in-patient program, at the out-patient clinic, were chosen for this research. This affected the selection of participants, as it automatically deleted the ones who fail to lose 5% of initial weight, at the out-patient clinic. That raises the question whether those who did not meet the criteria for the program would have another vision on the work of occupational therapy at the out-patient clinic. The participants were also chosen, based on their attendance at the occupational therapy. As some of the activities, led by the OT are an open invitation and not mandatory, the ones who came, were there because they wanted to. This of course affects the results and lessens any likelihood of negative inputs.

The researcher was located in Sweden but through her relations in Reykjalundur, she was assisted in finding participants for the focus group, which saved a lot of time. The use of a focus group was very appropriate for this research. The clients in the obesity program are used to working in groups when discussing their battle with obesity and their solutions to different problems. Discussions can also give more information than single interviews (DePoy & Gitlin, 1994/1999). It was therefore seen as more appropriate than interviewing six different persons at a possible six different locations during fieldwork in Iceland. This way, a variety of opinions was gathered in a shorter period of time than in individual interviews. The discussions in the focus group were beneficial to the purpose of the study, as the members provided back-up and imminent feedback to one another. The use of a focus group can also reduce the imbalance of power between the researcher and the focus group (Esterberg, 2002), which was seen as beneficial, given the researchers former relation to Reykjalundur.

The meeting was held in familiar surroundings to the clients and researcher. That likely contributed positively in regard to obtaining the clients opinions. It could also have affected them that the chief-occupational therapist was present or that the researcher was a former

occupational therapist in the obesity team. According to Wibeck (2000) it can be viewed as positive, when the researcher is someone who knows about the group-dynamics that can arise in this kind of program and understands their comments. The level of familiarity might also have enhanced the participant's belief in that what they were saying mattered, and would be considered of value in further planning for the program.

Keeping on track during the session was not always easy. The program is interdisciplinary and other members of the team were mentioned. The planning of gastric-bypass-surgery also received some attention. Recording the session did not seem to bother the participants. As this was a 'one time only' focus group, no prior assumptions were made on the matter by the researcher before entering this session, which is likely when there are more than one focus group sessions (Wibeck, 2000). The researcher has, however, attended several meetings of clients in the same program as the focus group, sessions that involve reflecting on the rehabilitation as a whole, rather than one part of it in particular. So this can be seen as a possibility of bias in the analysis.

When you get the same results from a given review question, from different researchers, at different times, the study is reliable. To increase the reliability of this study, it would be necessary to get other researchers to perform a content analysis, preferably someone outside of Reykjalundur. A person has a tendency to only hear and see what confirms his/hers opinions. In this study, the researcher is very likely to be influenced by the ten years experience, working as an occupational therapist. This might have affected the process of open coding, making it less open and more structured (Esterberg, 2002). This could also have influenced the content analysis validity. Validity lies in the interpretation of experiences and observations (Wibeck, 2000). The members of the focus group were discussing a topic that was close to them; they had all received the same kind of information and gone through the same kind of program. The session was held at a familiar place, although not in any of the rooms they had received occupational therapy or other sessions in the program. The researcher had no reason to fear that the clients were not speaking their minds. They were never asked to criticize the occupational therapy or give statements on anything that could have made them uncomfortable. They were reminded that there is no right or wrong answer in this kind of research.

This study contributes to what can be generalized about obesity and occupational therapy. By using a focus group, no statistical findings can be presented. The transferability depends on the one who receives the results and decides if he/she can apply it in another situation (Wibeck, 2000).

## **5.2. Discussion of results.**

The clients' knowledge on occupational therapy was little before the program. The ones, who had met with an OT before, did not see why there should be one in the obesity team. The others had no prior experience of occupational therapy. All of them stated that they would never have made an appointment with an OT, when or if they needed help with organizing or prioritizing their life, even if there was one at their local health clinic. It is obvious from this research that occupational therapy is not a well known resource in our society as means to battle obesity. But when the team physician did refer a client to an occupational therapist, they were appreciative. An OT could easily be more involved at local health clinics if the physicians were able to refer obese clients more frequently to occupational therapy. Rather than waiting for the physicians to start referring, OT's should, like Forhan (2008) stated, advocate for occupational therapy, in the area of treating or preventing obesity.

Meetings with the OT at the out-patient clinic helped the clients understand the role of routine in daily activity. Linking the food journal to daily activities made it easier to overcome. People disliked writing down what they ate, because it was too revealing of their diet, but they liked to plan the activities that were meaningful to them. When the main focus was moved away from the food and towards something meaningful to the clients, it provided them more stability and put the food journal into a more positive context. In doing this, all three components of MOHO were addressed. The motivation was enhanced (volition), the habits were questioned (habituation) and this affected the performance capacity. Writing the journal was now something pleasant and affected the individual's experience of way of life (the lived body).

To do something old in a new way, like shopping with the OT, helped the clients find a new way in coping with the everyday activity and increased their self-efficacy. Here the habituation is affected as body and mind try to figure out how to perform this activity in another way. Kielhofner says: "*Once we have grasped the feeling of how it is to do*

*something, repeating the performance is altogether different....we focus on the experience and use it as our guide to performing.” (2002:87).*

When attending sessions on the ability to handle life-stress and creating a balanced lifestyle, coping strategies, internal motivation, self-efficacy and goal setting, they felt as they were hearing something new, maybe because the context was new. They were not being told what they should do, but rather handed tools and the know-how to make changes. They said they experienced success when they did the assignments these sessions provided. That emphasizes the importance of doing, which surely is the focus of occupational therapy (Wilcock, 2006).

The participants were unanimous when describing arts and crafts, and the relaxation sessions at the occupational therapy, which. The need to *“forget about everything else”* and *“switch gears”* was obviously important to them. This leads to the conclusion that even though cognitive behavioral therapy and mindfulness are helpful when battling obesity (Stahre, 2002), the need to experience flow is still essential. Therefore, it is very important to combine different methods in rehabilitation for obesity. Some of the clients were attending arts and crafts or relaxation for the first time in their adult years and came because they self chose to. According to Kielhofner (2002), volition is an ongoing process of experiencing, interpreting and anticipating, when choosing occupations. These clients went beyond their usual habituation and performed new activities, thereby affecting their lived body.

The need for an ongoing support and strategies for the clients was obvious. This emphasizes the need for a regular follow-up, which could be available in their local community. This is not the case in Iceland; local health clinics mostly employ physicians and nurses. There is a need for a more diverse health service in the community. A support in maintaining the weight loss should come from each person’s social context in the near vicinity. An occupational therapist, using MOHO as her frame of reference, can help a client at a local health clinic to alter his motivation, values and interest. Habits and roles are thereby affected and a new experience, a new ‘lived body’ emerges through altered performance capacity.

I will end this discussion by using the words of Townsend and Britnell: *“Today, occupational therapists are generating knowledge of occupation for organizing time, creating balance, fulfilling particular purposes, prompting human development...coping with change...enhancing performance....responding to stress, and transforming oppressive*

*situations (...). Occupation is being explored as the day-to day basis for quality of life.....”*  
(2002:16).

### **5.3. Conclusion**

The possibilities of using occupational therapy as a means in treating for obesity must be presented to health authorities. To learn how to structure activities and prioritize meaningful activities is beneficial and could also be used to prevent obesity. The use of arts, crafts and relaxation is still actual within occupational therapy and the need for social support in ones vicinity is crucial.

When tackling obesity, which mostly is a result of lifestyle, I believe we have to look into peoples daily activities in terms of ability to handle life-stress, coping strategies and internal motivation. On a more practical note; to look at how they maintain balance between their various roles. The balance of work, family, leisure and recreation is the focus of occupational therapy. The emphasis is on occupation in daily activities, which includes everything people do for themselves and their families, what they contribute to their communities, their recreation and play. Occupational therapists enable performance and participation in people’s daily occupations. They prevent occupational problems and promote health by adapting occupations to the environment, and also by providing training, education, and consultation. Furthermore, occupational therapy contributes to health care policies by promoting environments and occupational opportunities necessary for human health and well-being. Occupational therapy can play an important role in battling the obesity epidemic with its contributions toward a healthy balance in daily activities, motivational skills and the use of purposeful and/or playful leisure activities. It is my hope that this study will provide its readers with some insight in using occupational therapy when treating for obesity, supporting weight maintenance and preventing unhealthy lifestyle, leading to obesity. Further research is needed to present health authorities with this possibility.

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## Appendix 1

### Focus group session.

Review question: How do clients in obesity rehabilitation at Reykjalundur experience the role of occupational therapy in the program?

1. The onset of treatment: prior experience of occupational therapy or expectations?
2. Occupational therapy at the out-patient clinic at Reykjalundur?
  - the focus of occupational therapy
  - assessment tools
  - sense of coherence in treatment
  - length of process
3. Occupational therapy during in-patient process at Reykjalundur?
  - words that come to mind
  - creating a balanced lifestyle
  - personal achievements, assignments
  - shopping and preparing food
  - arts/crafts and relaxation, extracurriculum
4. Discharge and follow-up?
  - appointments at out-patient clinic
  - obstacles
5. Occupational therapy in the community?
  - the local health clinic
  - other options in the community



