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The American Occupational Therapy Association

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The Role of OT in the Treatment of Incontinence and Pelvic Floor Disorders
Brenda Neumann, Jeannette Tries, and Mary Plummer describe both basic and advanced OT intervention in this emerging practice area.

An Assistive Technology Option: Assistance Dogs
Melissa Winkle and Brooke Zimmerman describe how dogs can overcome the barriers to using traditional AT.

Features

OT Practice serves as a comprehensive source for practical information to help occupational therapists and occupational therapy assistants to succeed professionally. OT Practice encourages a dialogue among members on professional concerns and views. The opinions and positions expressed by contributors are their own and not necessarily those of OT Practice’s editors or AOTA.

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Conference Update

Recharge your career!

Register now for the 2009 Annual Conference & Expo! Join us in Houston from April 23 to 26, and get in on the best opportunity of the year to learn, advance your skills, and more. In addition to more than 600 educational sessions, hundreds of leaders and potential employers, and thousands of colleagues will provide news, information, and discussion about the serious challenges OT faces. Be sure to visit the Expo Center, where over 300 exhibitors will be on hand to demonstrate and discuss products and services that are important to you and your practice. And while in the Expo, don’t miss the AOTA Member Resource Center and the AOTA Marketplace, where you can have member questions answered, visit the cyber café, buy the latest books on occupational therapy, and more! If ever there was a time to take advantage of top-notch learning that keeps your skills sharp, influential connections that open doors for career advancement, and peer interaction that inspires energy and creativity for your practice, this is it.

Conference Session Targets Ethical Issues in School-Based Practice

How do you maintain a child-centered focus while working collaboratively with parents and school personnel, especially when there may be administrative directives around allocation of resources, productivity, etc. that present ethical dilemmas? “ Everyday Ethics: Linking Research, Practice, and Ethical Decision-Making in School-Based Practice,” sponsored by the Ethics Commission (EC) of the American Occupational Therapy Association (AOTA), will identify ethical issues arising from both internal and external forces and the resources to assist you with decision-making challenges in the public schools. This short course will be held on Friday, April 24, from 8:00 a.m.–9:30 a.m. during the AOTA Annual Conference in Houston. The EC invites you to join in what is sure to be an informative and lively discussion.

RA Online Meeting

The Representative Assembly (RA), AOTA’s Congress for the profession, is currently meeting online via OT Connections (http://otconnections.aota.org/groups/ra_special_e-meeting/forum/default.aspx) to discuss and vote on six motions submitted by the membership. The motions are:

Definition of OT/OTA Roles within the Model Practice Act and All Other Relevant Documents; Specialized Knowledge and Skills Paper for Occupational Therapists in Oncology; Title Change for Occupational Therapy Assistants; Develop Model Requirements for Re-Entry/Re-Licensure; Ensure Broad Practice Area Representation Within the AOTA Board of Directors; and Building Diversity in Occupational Therapy Now To Meet the Centennial Vision.

To access all the reports and these motions, go to the AOTA Web site (www.aota.org) Leadership & Governance, Representative Assembly, Online. The meeting ends April 10.

Results of the 2009 AOTA Elections

The Nominating Committee is pleased to announce the results of the 2009 AOTA elections, which concluded on February 18. A special thanks to all the candidates who were so willing to serve the Association and to all the members who took the time to vote.

GENERAL ELECTION

Florence Clark
President-Elect

Virginia “Ginny” Stoffel
Vice President

Thomas Fisher
Board Director

Coralie “Corky” Glantz
Board Director

Jyothi Gupta
Commission on Education Chairperson-Elect

Barbara Hemphill
Ethics Commission Chairperson-Elect

Michele Luther-Krug
OTA Representative to the RA

SPECIAL INTEREST SECTIONS

Tara Glennon, AMSIS Chair

Leslie Jackson, EIISIS Chair

Missi Zahoransky, HCHSIS Chair

Tina Champagne, MHSIS Chair

ASSEMBLY OF STUDENT DELEGATES

Ryan Morgan
Chairperson

Kayla Chambers
OTA Vice Chairperson

AOTA Updates

Conference Update

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Kayla Chambers
OTA Vice Chairperson

Association updates...profession and industry news

Janelle Murray
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Elizabeth Hayes
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Jennifer Cruz
Representation to the Commission on Practice

OT Practice

Thanks Reviewers

The staff members of OT Practice thank the following persons for sharing their expertise by providing content reviews of manuscripts and articles for the issues from January 19 through March 23:

Salvador Bondoc, Jyothi Gupta, Neil Harvison, Valerie Hermann, Donna Latella, Deborah Lieberman, Maria Elena Louch, Stacy Nelson, Maureen Peterson, Deborah Pitts, Laurel Radley, Linda Riccio, Denise Rotert, and Tracy Van Oss.

OT Month

2009 Catalog Available Now!

OTA members received the 2009 Occupational Therapy Month catalog in January. It is also available online at www.promoteot.com and is filled with great ideas and fun products to show your pride in being an occupational therapy practitioner. AOTA members know better than anyone that occupational therapy helps people of all ages live life to its fullest. Take advantage of your knowledge, network, and 2009 OT Month resources to help educate others!

continued on page 4
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NEW FROM AOTA PRESS
Screening Adult Neurologic Populations
By Sharon A. Gutman, PhD, OTR/L, and Alison B. Schonfeld, OTR/L
This updated manual guides occupational therapists through the entire screening process in an easy-to-use format. It provides detailed steps for cognitive, functional visual, perceptual, sensory, motor, cerebellar function, cranial nerve function, neuropathy, peripheral nerve function, and dysphagia screening, in addition to a new section on mental status. Contains forms and case study on CD-ROM.
$68 for Members, $97 for Nonmembers. Order #4832-BB

AOTA Secures Voting Rights on AMA Body Responsible for Quality Measure Development

After nearly 2 years of advocacy with the American Medical Association’s Physician Consortium for Performance Improvement (AMA-PCPI), AOTA and other health care professional organizations now have the opportunity to vote on specific final draft quality measures. Previously, only physicians had the right to vote on measures. As a non-voting member, AOTA had been able to participate in measure development workgroups, propose topics for measure development relevant to occupational therapy, and review and comment on all measures. AOTAs right to cast a vote through a representative at AMA-PCPI meetings will enhance our influence in measure development and provide a critical voice in future thinking about what qualifies as quality health care. To learn more about AMA-PCPI, visit www.ama-assn.org.

Final Guidelines for CIMT in Pediatrics

In the October 8, 2007, issue of OT Practice, therapists Pamela Little-Hayes, OTR/L, Allison Alligier, OTR/L, Amy Klein, OTR/L, Rebecca Reder, OTR/L, and Carol Burch, PT, PTD, from Cincinnati Children’s Hospital, published the article “Embracing the Spirit of Inquiry,” which discussed their process of developing evidence-based guidelines for using constraint-induced movement therapy (CIMT) in pediatrics. They have finalized the guidelines, and Cincinnati Children’s Hospital has posted them at www.cincinnatichildrens.org. Type “evidence-based pediatric care guidelines” into the search box, and click on the first link under the “Services” subhead.

Change in Registration Process

As of March 1, 2009, purchasers of AOTA Self-Paced Clinical Courses who want to obtain nondegree graduate credit from Colorado State University (CSU) must register directly with CSU when submitting the exam to AOTA for scoring. To obtain nondegree credit from CSU, the following is required: contact CSU to obtain the most current registration form; send CSU a completed registration form and make a copy of the form to submit to AOTA with your exam; and submit your completed exam and a copy of your completed CSU registration form to AOTA for scoring. AOTA will notify you and CSU of your completion status. Terms and conditions apply. Visit www.aota.org, and click on CE, then Self-Paced Clinical Courses, for more information.

Research Highlights

Grant for CarFit Project

The University of Minnesota’s (UM’s) master’s of occupational therapy students Lauren Belinkoff and Theresa Omlstead have received funding from the National Center on Senior Transportation (NCST) for their project “Creating and validating an online CarFit training program for occupational therapists.” The project continues work done last year by occupational therapy students Cristina Curtis and Lindsey...
Wegner. “Tina and Lindsey really broke the ground with their pilot showing what this online program could look like,” notes Erica Stern, PhD, OTR/L, a faculty member who mentors all four students.

Sponsored by AAA, AARP, and AOTA, CarFit is a national program that works to help older adults drive longer, safely. Says Stern, “AAA and AARP were initially hesitant about using online education. The first two students’ pilot let them appreciate what this technology can provide and brought them enthusiastically on board. Now, with the NCST’s support, Lauren and Theresa will bring this idea to full realization and validate its efficacy.”

“If successful, this project will help reduce the barriers associated with occupational therapists’ CarFit training, by allowing them to learn on their own timeline and from their own homes, and reducing the time that they need to be at a CarFit event from 2 days to 1,” says Elin Schold Davis, OTR/L, CDRS, a collaborator on the project and the coordinator of AOTA’s Older Driver Initiative. The validation phase of the project will determine whether the project can reduce the geographic barriers of current CarFit training while retaining the skill levels needed for effective events.

“In Memoriam

Beverly Mae Konugres Bain, a renowned occupational therapist, passed away in February. Bain was an internationally known pioneer in the field of occupational therapy and rehabilitation. She graduated from Colorado College, earned a master’s degree in occupational therapy from the University of Southern California, an MS in learning disabilities from Montclair State University, an EdD from Fairleigh Dickinson University, and was a Fellow of the American Occupational Therapy Association. She completed a postgraduate fellowship at the Rehabilitation Institute in Warm Springs, Georgia, during the last polio epidemic; was personally recruited by Dr. Henry Kessler and directed the OT department in the Kessler Institute in West Orange; and created the AMA-accredited 4-year OT program at Kean College and a 2-year assistant OT program at Union County Technical Institute. Bain was also an assistant professor in the graduate OT program at NYU for 18 years, and was appointed by President Nixon to the Defense Advisory Committee on Women in the Armed Services, which integrated women in the military and academies. She also authored numerous papers on rehabilitation, including 18 chapters in medical textbooks. Bain lectured on rehabilitation throughout the U.S. and abroad, was invited by the government of Iceland to consult and lecture on rehabilitation, and was a member of the Rehabilitation Engineering and Assistive Technology Society.

Molly V. Strzelecki is the associate editor of OT Practice.

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Challenges to the occupational therapy scope of practice continued during the 2009 state legislative sessions. At the same time, state legislatures are moving forward with bills to strengthen the occupational therapy scope of practice.

**STATE REGULATION OF OT**

Michigan Governor Jennifer M. Granholm signed Senate Bill 921 to license occupational therapists and occupational therapy assistants on January 12. The bill also revises the state’s definition of “practice of occupational therapy” based on the AOTA Model Practice Act and establishes continuing education requirements for licensure renewal. OTs are now licensed in 48 states, and OTAs are licensed in 45 states. Congratulations to the Michigan Occupational Therapy Association.

Bills in Idaho and West Virginia propose revising the definition of occupational therapy practice based on language from AOTA’s Model Practice Act definition, while legislation pending in Washington State would specifically authorize OTs to use medications in their practice. Idaho House Bill 171 is pending in the House Business Committee. West Virginia House Bill 2309 passed on February 23 and is pending in the Senate. Washington House Bill 1041 passed on February 13 and is pending in the Senate.

**PHYSICAL THERAPY**

In Utah, legislation to revise the physical therapy practice act has passed the Senate and is pending in the House. Senate Bill 137 would revise the definition of physical therapy to include “functional training in self-care.” The limited context in which PTs address functional training is not clearly defined, which may mislead consumers and encroach on the traditional domain of OT. The Oregon Physical Therapy Licensing Board proposed regulations to adopt similar language. The Occupational Therapy Association of Oregon (OTAO), with assistance from AOTA, persuaded the Board to clarify that PT intervention includes “functional training related to physical movement and mobility in self-care.”

**ORTHOTICS AND PROSTHETICS**

Legislation to license orthotists and prosthetists was recently introduced in Oregon, Kentucky, and New York. The Kentucky bill exempts licensed OTs due to advocacy by the Kentucky Occupational Therapy (KOTA) Association. The New York Occupational Therapy Association will press for exemption language. The Oregon bill was withdrawn soon after it was introduced, but OTAO expects it to be reintroduced in 2010. All existing O&P licensure laws exempt OTs.

As reported in the February 2nd Capital Briefing article, the American Orthotics and Prosthetics Association considers exemption language for OTs to be “inappropriate” and “may defeat the purpose of licensure.” This is especially interesting given AOPA’s strategic plan to expand the role of O&Ps. In a document provided to AOPA members (“Strategic Planning Initiatives of the American Orthotic & Prosthetic Association as Presented to the Membership September 11, 2008”) and posted to its Web site, the association plans to pursue “alternative revenue generating business models” including “offering expanded services to include physical therapy and/or occupational therapy services including: gait training, massage therapy, stretching and strengthening therapy, therapy to improve activities of daily living, developing the necessary skills needed in returning to the workplace, etc.”

**ART THERAPY**

Legislation to license art therapists has passed the House in Kentucky. The bill defines “the practice of professional art therapy” as the “integrated use of psychotherapeutic principles, visual art media, and the creative process in the assessment, treatment, and remediation of psychosocial, emotional, cognitive, physical, and development disorders in children, adolescents, adults, families, and groups.” KOTA lobbied to secure exemption language for OTs.

**AOTA AND STATE ASSOCIATIONS**

**ADVOCACY INITIATIVES**

AOTAs State Affairs Group electronically monitors state legislative and regulatory issues in all 50 states, the District of Columbia, and Puerto Rico to identify proposals when they are introduced. We work with state associations to be proactive on these issues. Your membership in AOTA and your state association provides the resources to assert and protect occupational therapy’s domain in state licensure laws.

An update on state policy issues will be provided at the State Legislative and Regulatory Affairs Forum during AOTA’s Annual Conference and Expo in Houston. The Forum (SC 400) will be held on Sunday, April 26, from 9:00 to 10:30 a.m. AOTA staff and guest speakers from state associations will discuss OT legislation and state initiatives to address a variety of scope of practice challenges from other health professions.

Chuck Willmarth is the director, state affairs, at AOTA. He can be reached at cwillmarth@aota.org.
As a self-employed occupational therapist, Twilla Parr, MS, OTR/L, knows how to keep her career interesting. As of late, her practice focuses predominantly on her role as a First-Steps early intervention provider for the state of Kentucky. She also performs vocational assessments for a local career service that contracts with vocational rehab. And if that weren’t enough to keep Parr on her toes, she is also a certified aging in place specialist (CAPS), adding this consultant service to her private practice.

Oh, and she’s also pursuing a PhD in rehabilitation science at the University of Kentucky. And occupational therapy? Not her first career, either. Like many practitioners, Parr came to the profession after a career in another field; in her case, it was interior design. “I’ve always been very function oriented,” Parr says. However, the pretentious nature of design eventually soured her to the industry, she explains.

“I wanted to work with people and help them with their design no matter what kind of money they wanted to spend,” she notes. “It didn’t matter to me. But I ended up working very hard for less money [than other designers], because everything is commission driven.”

Thankfully, Parr had a friend who was an occupational therapist and the way she described her work intrigued Parr. “The creative aspect of occupational therapy really interested me in a journey toward the profession,” Parr notes, and it pushed her into looking into occupational therapy programs. She eventually earned a postbaccalaureate certificate in occupational therapy at Eastern Kentucky University. When working on this certificate her ideas of combining the knowledge of both interior design and occupational therapy were not well received by the faculty, given the limited educational offerings at the time. Some 13 years later she returned to Eastern Kentucky University to obtain her master’s degree in occupational therapy. Because home modifications was an emerging practice area, and there was a renewed focus on more client-centered, occupation-based practice, her desire to study occupation and the environment was now welcomed.

Now working on her PhD, Parr notes that the multidisciplinary program—which includes speech-language pathologists, physical therapists, athletic trainers, and of course other occupational therapists—is ideal for her background.

“It’s exciting to see so much interest in what occupational therapy has to bring to the program,” Parr notes. “It’s enlightening to the students from other fields how we view function, and the other professions have tremendous knowledge to contribute to rehabilitation science as well. The great thing about occupational therapy is that we’re willing to look at the multiple facets of an individual to gain an increased understanding of participation and health.”

For her research, Parr is combining her experience in occupational therapy with her experience in interior design, focusing on and emphasizing the environmental impact on function. With this idea, Parr approached the design department at the University of Kentucky, which included some professors who were still there from when she was a student obtaining a bachelor’s degree in design.

“We started a collaboration that involves lectures and getting involved with the design projects that the students are completing, trying to make them more sensitive to the needs of diverse populations, and introducing global perspectives of occupation/participation and how it relates to health.” Parr explains. “It’s exciting, coming back to the department in this capacity, and it was serendipitous because the design faculty had just been challenged with expanding beyond their department and working with other...
departments of the university.” In addition, Parr says, the collaboration includes a research project to find out about the young designers’ attitudes on disability and whether they are open to collaboration with the occupational therapists.

“We want to see what [students’] attitudes are, as these are the attitudes of professionals of the future. Many occupational therapists are becoming certified aging in place specialists, assuming that the design profession will accept our assistance to meet clients’ needs, when in fact designers are most likely unaware of the contribution we could make to understanding and addressing the needs of their clients. The entire point of this early investigation is to increase awareness of new designers and to improve the possibility of collaboration with occupational therapy when they are working professionals.” Parr feels this preservice educational collaboration is important because occupational therapists are not designers.

“Occupational therapists must approach the design profession with the same sensitivity that we offer our clients or other professionals. We should think of [designers] as ‘environmental therapists,’” she explains. “Creating interiors that support function requires the input from various professions. We cannot claim to know it all, but our profession does have a unique contribution toward the success of the project.”

From her research, Parr hopes to develop a model of practice for therapists when they are participating in the creation of new or modified interiors. She believes that occupational therapy intervention in home modification needs to be considered beyond the individual, to the community and population levels. “There is the potential for a larger application of these services to impact occupation and health. I hope my research will demonstrate the effectiveness of these services to impact policy so that resources will be available to permit people to age in place,” she says.

“Having the evidence that supports occupational therapy’s involvement in this area and collaboration with other professionals to assure function on a community scale is the future of the profession,” Parr says.

All of which makes for one well-designed career.

Twilla Parr, MS, OTR/L, CAPS, is an occupational therapist working in private practice in Lexington, Kentucky. She has worked for many years providing services in the community, school, and clinical settings. She is also a doctoral student in rehabilitation science at the University of Kentucky.

Molly V. Strzelecki is the associate editor of OT Practice.

Nondiscrimination and Inclusion

James Marc-Aurele

The position paper “Occupational Therapy’s Commitment to Nondiscrimination and Inclusion” articulates not only the philosophical basis for nondiscrimination and inclusion, but also operationalizes these concepts. By embracing nondiscrimination and inclusion we benefit from the richness of diversity both as a profession and as members of society.

Vital to the foundation of nondiscrimination is the principle of equality; when we treat individuals equally we are avoiding bias and prejudice. Equality, which is also a core value of the profession, is the belief that all individuals possess the same fundamental human rights and opportunities, reaching well beyond legal mandates.

A position paper describing the profession’s stance on nondiscrimination and inclusion should not surprise us. As occupational therapy practitioners, educators, and Association members, we embrace the value of the individual while affirming the right of everyone to access and fully participate in society. At the surface, few would argue the philosophical merit of nondiscrimination and inclusion as vital to our profession. However, as with any position paper, only our actions can move our profession’s stance on nondiscrimination and inclusion.

In order to accomplish this we must reflect on our own practice. Do we value our clients, respecting their culture, ethnicity, race, age, religion, gender, sexual orientation, and capacities, as defined and described in the Occupational Therapy Code of Ethics (2005)? From a practical standpoint, this involves choosing evaluation methodology and intervention strategies that are age appropriate and culturally sensitive and do not subject the individual to bias. At the same time, we must consider the multitude of contexts that affect our clients’ abilities to engage in daily occupations as described in the Occupational Therapy Practice Framework: Domain and Process. Do we actively engage clients, their families, and significant others as part of the occupational therapy process? Our intervention strategies must take into account the contexts that are valued by the individual, while working toward client goals.

These same challenges exist for us as educators. Do we consider the unique individual characteristics of our students in fostering their development as occupational therapy practitioners? Our teaching methodologies must take into account not only diversity in learning style, but also social, cultural, ethnic, and personal diversity as well.

The answers to these critical questions can be neither scripted nor prescribed. Each situation calls us to critically evaluate a multitude of contextual factors. The position paper serves as a valuable tool for describing the principles that should guide our actions. We must reflect on our own values, beliefs, and actions to determine how we can, in our daily practice, exemplify and affirm the profession’s commitment to nondiscrimination and inclusion.

References


James Marc-Aurele, MBA, OTR/L, is the clinical supervisor of occupational therapy for Mid Coast Hospital in Brunswick, Maine, and is a member of AOTA’s Commission on Practice.

AOTA Commission on Practice

Twilla Parr, MS, OTR/L, CAPS, is an occupational therapist working in private practice in Lexington, Kentucky. She has worked for many years providing services in the community, school, and clinical settings. She is also a doctoral student in rehabilitation science at the University of Kentucky.

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The Role of OT in the Treatment of Incontinence and Pelvic Floor Disorders

BRENDA NEUMANN
JEANNETTE TRIES
MARY PLUMMER

“I don’t like to go anywhere because I am constantly looking for a bathroom, so I just stay home.”

“This isn’t something you usually talk to anyone about. It was psychologically affecting me. It made me want to become a hermit. I felt trapped.”

Conservative estimates indicate that in the United States 16% of the female population suffer from urinary incontinence (UI) and 9% suffer from fecal incontinence.1 About 33% of the U.S. population report symptoms of overactive bladder, a condition characterized by urinary urgency, frequency, and night-time voiding.2 Many others experience pelvic floor disorders such as pelvic pain.

COSTS AND PERSONAL IMPACT
The direct medical costs related to urinary incontinence and overactive bladder are estimated at more than $23 billion annually in the U.S. Indirect costs, including lost productivity, increase this estimate to more than $32 billion.3 What can’t be measured in terms of dollars is the profound impact of incontinence and pelvic floor disorders on occupation, the daily activities that give life meaning. Impairments in bowel, bladder, and urogenital function can result in depression, loss of self-esteem, and difficulty maintaining a healthy and independent lifestyle and fulfilling relationships.4,6 Activities outside the home, social interactions with friends and family, and sexual activity may be restricted or avoided entirely.7–9 UI is recognized as one of the leading conditions associated with functional decline and institutionalization of the elderly.10–12

Treatment for incontinence and pelvic floor disorders generally falls into three major categories: surgical, pharmacological, and behavioral. Surgical and pharmacological treatments are the options most familiar to clients and physicians. Recently however, published medical practice guidelines have advised using conservative treatments before surgery.10,13–15 Conservative treatments refer to behavioral techniques alone or in conjunction with pharmacological treatments. Behavioral techniques for incontinence include routine or scheduled toileting, habit training, prompted voiding, bowel and bladder retraining, dietary and fluid modification, and pelvic muscle rehabilitation. Over the past 5 to 10 years, the attention given to the usefulness of behavioral techniques has given rise to an increased market for rehabilitation services aimed to improve bowel, bladder, and pelvic floor disorders.

THE ROLE OF OCCUPATIONAL THERAPY
Rehabilitation for bowel, bladder, and pelvic floor disorders requires a comprehensive approach that addresses their complexity. According to AOTA’s Scope of Practice position paper16 and the Occupational Therapy Practice Framework: Domain and Process (Framework),17 conservative treatment of incontinence and pelvic floor disorders is within the domain of occupational therapy “as it is related to supporting performance and engagement in occupations and activities targeted for intervention” (p. 636).17 Occupational therapists provide a comprehensive approach that looks beyond musculoskeletal skills deficits and recognizes the need for changes in performance patterns, such as habits and routines, while also considering the context and activity demands related to the problem. Additionally, occupational therapy practitioners have the background and training to understand the related distress and provide support for the psychosocial aspects of these disorders. Depending on their level of training, occupational therapy practitioners may provide either basic or advanced intervention for incontinence and pelvic floor disorders.

BASIC OCCUPATIONAL THERAPY INTERVENTION
All occupational therapy practitioners have the education and clinical skills to provide basic intervention for incontinence. Basic intervention includes assessing and training for deficits in functional self-care skills that may be contributing to the incontinence. These deficits can include physical problems such as managing clothing, performing hygiene, and transferring to the toilet, as well as cognitive deficits such as remembering to void or locating the toilet. Occupational therapy practitioners address the component skills that contribute to these functions, such as upper-extremity range of motion, fine motor coordination, grip-and pinch strength, cognitive and sequencing skills, trunk mobility and balance, and functional mobility as they relate to toileting. Therapists also assess the need for adaptive equipment or techniques (e.g., raised toilet seats, adapted clothing fasteners, urine collection devices, protective pads or garments) and provide training in adapted techniques for

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intermittent self-catherization, adapted handles or methods for suppository insertion, digital stimulation, and toileting hygiene. When appropriate, they train caregivers in the use of the adaptive devices and methods, or the use of scheduled or prompted toileting interventions. These interventions are often helpful for persons who have cognitive deficits or who reside in institutions18 (e.g., a nursing home resident with mid-stage dementia who cannot remember to void or cannot locate the bathroom independently).

**ADVANCED OCCUPATIONAL THERAPY INTERVENTION**

The Framework states, “Some therapists may specialize in evaluating and intervening with a specific function, such as incontinence and pelvic floor disorders, as it is related to supporting performance and engagement in occupations and activities targeted for intervention” (p. 636).17 Specialized or advanced occupational therapy intervention requires the therapist to understand body functions such as urinary, digestive system, and reproductive functions and involves administering specific assessments and treatment for pelvic floor muscle dysfunction. This level of intervention requires a motivated client who has the cognitive function to take an active role in the process and is commonly provided in an outpatient setting.

Occupational therapists must demonstrate competency before the delivery of advanced intervention. Competency can be obtained through continuing education, comprehensive clinical training with a qualified mentor, or certification through an accredited training program such as the Biofeedback Certification Institute of America (www.bcia.org). Occupational therapy practitioners are required to abide by state laws (occupational therapy practice act) and other regulatory requirements to determine scope of practice related to incontinence.

**Assessments**

**Functional Assessment**

Specialized or advanced occupational therapy intervention begins with a functional assessment of bowel, bladder, and sexual function. This information is obtained through client voiding diaries, interview or self-report, and a review of pertinent medical and diagnostic tests. During the functional assessment, the therapist specifically evaluates how the client’s impairments are affecting occupational performance and engagement in everyday activities, such as attending church or community activities, gardening or exercising, or engaging in sexual activity. During the assessment, clients disclose very personal information, so it is important to promote rapport by providing ample time and an environment that ensures privacy and promotes trust.

The functional assessment includes an analysis of habits, routines, and behaviors that may be contributing to the problem. For example, consuming too much caffeine, a bladder irritant, may contribute to bladder urgency and incontinence. It is important to identify this habit during the assessment because it may need to be altered for a successful outcome. Identifying maladaptive behaviors associated with bladder urgency and incontinence such as voiding “just in case” or too frequently to preempt urgency or incontinence is also important because they can create further dysfunction and a lack of response to treatment.

Context is also evaluated to help identify specific situations in which the problem occurs. An example is the so-called “key-in-the-lock urgency” when entering one’s home. Common activity demands that contribute to incontinence include sit-to-stand movements, bending, lifting, coughing, and laughing. Evaluating the behaviors, habits, context, and activities associated with incontinence can help facilitate a comprehensive, client-centered approach.

**Pelvic Floor Muscle (PFM) Assessment**

After the functional assessment, occupational therapists with advanced training may provide a comprehensive pelvic floor muscle (PFM) assessment. This evaluation is useful because PFM dysfunction is often an underlying cause of incontinence and pelvic floor disorders. Neuromusculoskeletal assessment includes PFM strength, tone, isolation, and coordination as
they relate to bowel, bladder, and sexual function. Assessment may involve a standardized digital exam of the vagina and/or anal canal using a 0 to 5 grading scale (0 = no contraction; 5 = strong squeeze, good lift, repeatable) and/or PFM surface electromyography (biofeedback) using vaginal and/or anal sensors.19,20 Palpation to assess for soft tissue mobility and/or pain in the pelvic floor and surrounding tissues may also be performed.

**INTERVENTION**

**Pelvic Floor Muscle Re-education**

PFM re-education is used to improve PFM strength and endurance, train functional PFM relaxation and coordination, and teach inhibition of maladaptive motor responses. PFM re-education often involves electromyography (EMG) or biofeedback and includes a progressive home exercise program. Biofeedback is a valuable tool for PFM re-education, in some cases reducing UI by as much as 80%.21,24,25 In cases of profound PFM weakness, or as a method to inhibit persistent symptoms of overactive bladder, PFM stimulation may be used in conjunction with PFM re-education. Though research outcomes vary, some studies support the value of pelvic floor muscle electrical stimulation to reduce incontinence.26-28

As the PFM re-education progresses over a series of treatments, clients are taught to integrate their skills into daily activities. For example, they may learn how to inhibit an overwhelming urge to urinate or evacuate that may precede incontinence (see Table 1)29 and reduce maladaptive and potentially harmful behaviors, such as rushing to the toilet. Successfully applying this skill can give clients the confidence to participate in activities outside of their home.

**Bladder and Bowl Retraining**

Bladder and bowel retraining is used to restore normal daily function. Bladder training aims to increase the bladder’s storage capacity by changing voiding habits or behaviors and progressively delaying the urge to void. In contrast, for persons with abnormally large bladders, bladder training may involve using a more frequent or scheduled voiding pattern. Bladder training has been shown to reduce episodes of UI by at least 50%.30

Bowel retraining involves teaching strategies to improve the consistency of stool, establish a regular, predictable time for elimination; and stimulate emptying on a routine basis. As elimination becomes more regular and predictable, and stools become more formed and easier to control, individuals become less fearful of having an incontinent episode in public and are more confident leaving home. This reduces their tendency to become isolated or homebound.31

**Diet and Fluid Instruction**

Some foods and beverages irritate the bladder or bowel, creating the sensation of urgency and causing frequency or leakage. The amount and timing of fluid intake also has an influence on function. During intervention for incontinence, practitioners educate clients in applicable dietary and fluid influences and address behavioral changes. These simple changes can have a profound effect on bowel and bladder control, yet if overlooked they can preclude a successful outcome. Common dietary irritants include caffeine, citrus juice and fruit, alcohol, tomato-based products, artificial sweeteners, and spices.32,33

**Pain Desensitization**

When pain or soft tissue restriction impairs bowel, bladder, and sexual function, occupational therapy intervention may include desensitization techniques and soft tissue mobilization. Clients may be taught to use vaginal dilators, soft tissue massage, and relaxation strategies as part of their home program.

**CASE EXAMPLE**

The following example demonstrates an occupational therapy approach to urinary continence/overactive bladder.

Irene is a 72-year-old woman who was referred to occupational therapy for bladder urgency, frequency, and incontinence. In the months prior to her referral her problem had gradually worsened, and her fear of having an incontinent episode in public had caused her to become homebound. Irene also had constipation, which affected her quality of life and contributed to her UI. The occupational therapist educated Irene on the role of diet and suggested that she reduce her caffeine intake and increase her dietary fiber. PFM re-education was provided. As Irene gained better control of her pelvic floor muscles, she was taught how to inhibit bladder urges, particularly when she was out in the community. She was also taught how to relax her PFMs during a bowel movement. Over the course of therapy, Irene’s bowel patterns became more regular and she was able to control her bladder urges, significantly reducing her urinary frequency and incontinence. As Irene’s bladder control improved, she had the confidence to attend church services and engage in community activities. She was also able to resume her twice-weekly exercise group.

**OPPORTUNITY FOR OCCUPATIONAL THERAPY**

Incontinence and pelvic floor disorders are common problems that profoundly affect one’s ability to function in daily life. Due to the personal nature of these problems and their embarrassing symptoms, many people fail to seek help from their health care provider.34 As occupational therapy practitioners, we address intimate self-care skills. We are therefore well suited to identify and assist clients with incontinence problems. The words of a client describe the potential impact of our intervention: “This has been a lifesaver. I didn’t know what to
do or where to turn...I couldn’t go on with my normal life the way it was.”

The conservative treatment of incontinence and pelvic floor disorders is an effective and underdeveloped area of rehabilitation that occupational therapy practitioners are qualified to expand. This area of practice holds great potential and reward for professional growth. More importantly, developing this area of practice has the potential to affect many persons with these problems. ■

Brenda Neumann, OTR, BCIAC-PMDB; Jeannette Tries, PhD, OTR, BCIAC-PMDB; and Mary Plummer, OTR, BCIAC-PMDB, practice at the Center for Continence and Pelvic Floor Disorders at Aurora West Allis Medical Center in Milwaukee, Wisconsin, treating both women and men with incontinence and pelvic floor disorders. They share more than 50 years of experience in this treatment area and provide training and mentoring to health care professionals interested in this topic. Please direct correspondence to Brenda Neumann at bneumann@wi.rr.com.

Brenda Neumann and Tiffany Lee will be presenting a workshop at AOTA’s Annual Conference & Expo in Houston titled “An Introduction to the Treatment of Incontinence” on Sunday, April 26.

References

FOR MORE INFORMATION
PUBLICATIONS
Biofeedback: A Practitioner’s Guide

Disorders Related to Excessive Pelvic Floor Muscle Tension

Strategies for Establishing Bowel Control

TRAINING/COMPETENCY
Biofeedback Certification Institute of America (BCIA)
Offers certification in pelvic floor muscle dysfunction biofeedback http://www.bcia.org or 866-908-8713

Treatment of Bowel, Bladder, and Pelvic Floor Disorders
Marquette University, June 17–20, 2009
An annual course with occupational therapy faculty that meets didactic and practicum requirements for certification through BCIA. www.marquette.edu/chs/cont-ed/pelvic.shtml

ORGANIZATIONS
International Foundation for Functional Gastrointestinal Disorders www.ifgfd.org or 888-964-2001

National Association for Continence www.nafc.org or 1-800-bladder

Society of Urologic Nurses and Associates www.suna.org or 888-827-7882

Continued on page 18
The benefits of animal assisted therapy as an occupational therapy modality are supported in the literature. However, many practitioners are not aware of the professional role of assistance dogs as an assistive technology (AT) option. The services offered by assistance dogs are not the same as those offered during animal assisted therapy. Although both have therapeutic value, animal assisted therapy involves a health or human services professional and a qualified animal working as a team to meet specific measurable goals. Assistance dogs are formally trained for and permanently placed with individuals who have physical disabilities, seizures, diabetes, visual or hearing impairments, autism, or psychiatric disabilities.

**AT USE AND ABANDONMENT**

The AT abandonment rate is approximately 33% and frequently occurs within the first 3 months of procurement. Abandonment results from providers not fully considering the client’s opinion and preferences, changes in functional ability, ineffectiveness of the device, decreased motivation, lack of training, device stigma, accessibility issues, and/or insufficient maintenance and repair information. Proper AT placement should focus on improved physical functioning and well-being, quality of life, social participation within meaningful contexts, and a decreased need for assistance from others. For some people, assistance dogs can facilitate these outcomes.

**TYPES OF ASSISTANCE DOGS**

Even if you aren’t involved in training or placing an assistance dog, you can help facilitate the process for a client by understanding the different jobs that dogs can do and the standards that both the dogs and clients must meet to be considered for placement. According to Assistance Dogs International (ADI), assistance dog is a general term that refers to three specific subcategories: guide dogs, hearing dogs, and service dogs.

Guide dogs serve individuals with visual impairments or blindness. They are trained for basic obedience and skilled tasks, including guiding around obstacles or overhangs, crossing streets, and accessing public transportation. The recipient must be able to give directional cues. The dog must respond to voice commands or hand signals in all environments, and walk in a controlled position next to the handler. The dog’s role includes ensuring the team’s safety by disobeying unsafe commands, such as refusing to walk into traffic.

Hearing dogs assist people who have hearing impairments or are deaf. Dogs alert their owners to common household or work sounds, including alarms, doorbells, the person’s name being called, timers, and even crying children. The dogs are trained to respond to basic
obedience via voice or hand signals, alert to at least three sounds (each within 15 seconds from the start), and demonstrate physical contact or some other behavior to indicate the sound’s source.12

Service dogs may be trained to perform a broad scope of tasks for people with conditions other than visual or hearing disabilities.12 In one study, owners reported that service dogs assisted them in 28 functional tasks, which resulted in a decreased need for paid assistance by 2 hours per week and a decreased need for unpaid assistance by 6 hours per week, allowing for increased privacy and autonomy.13 Individuals with neuromusculoskeletal dysfunction may ask service dogs to operate an out-of-reach automatic door opener, immediately retrieve dropped items, provide balance and counter-balance for transitional movements, and open doors and drawers to help conserve energy for more meaningful activities. Service dogs are capable of gathering activities of daily living (ADL) supplies and can offer assistance with dressing and undressing activities.

Some dogs have the gift of detecting a seizure or a diabetic emergency before or during the occurrence and can be trained to alert the handler or a caregiver. They may also be trained to prevent and respond to a crisis by carrying medical supplies in a backpack, incessantly barking to draw attention, retrieving a phone or using a call switch to activate emergency services, or staying by the handler’s side as he or she becomes reoriented after an episode.14 Some dogs also are trained for individuals with autism, as they are capable of decreasing wandering and flight responses, and can perform search-and-rescue tasks.15 Other dogs are trained to assist individuals with psychiatric disabilities by carrying medications, alerting to over sedation, decreasing panic and anxiety, and providing reality orientation.16

Additional documented benefits of assistance dogs as a group include improved social interaction and social competence (by increasing the duration, frequency, and comfort level of interactions); psychosocial function (by decreasing depression, anxiety, and loneliness); life satisfaction (by increasing the duration and comfort level of interactions); and increased feelings of self-efficacy and control.17

M y journey to obtaining a service dog began after I took a particularly nasty fall in my home. I have limb girdle muscular dystrophy, which causes limited mobility and poor balance. I had to painstakingly crawl from the living room to the sunroom, at the opposite end of the house, to reach the telephone. After calling for help, I had to crawl back to the front door to unlock it and let my neighbors in. Lying on the floor in an exhausted heap, I thought, “There must be a better way.”

Some might recommend a lock box or a medical alert button. Although I did get a lock box, the medical alert system seemed like something for old people, and I wasn’t crazy about having strangers come to my aid. Besides, I love animals and I thought an assistance dog would be a wonderful way to have the best of both worlds—a furry companion and a helper.

I began researching assistance dog programs and found that many required long distance travel, extended training time, or a lot of money. With a full-time job and a disability, it seemed out of the question. Further investigation led me to Assistance Dogs of the West (ADW), only an hour from my home. The program felt smaller and seemed to offer more individualized service. There was even a functional evaluation and needs assessment by an occupational therapist, which was a required part of my application.

I periodically traveled to ADW for the interview process, which involved meeting with the trainer and a series of dogs in effort to make a good “match.” That is when Fenn, a handsome and very social Labrador retriever, selected me. I took 2 weeks off of work and went to the placement training to learn about dog behavior, grooming, health, and the language Fenn was trained with. These 2 intensive weeks were both physically and mentally draining, but this is also when our human–animal bond (personal and professional) began. This type of placement training is typical of many programs, and I needed to enlist the aid of a family member during this time to help me with personal care needs—a factor to consider when one is applying for a dog.

It has been almost 4 years since I was placed with Fenn. The first 6 months or so were very tiring because I was constantly on high alert, making sure he was under my control 24/7. Now I can better anticipate his needs and behavior, and it’s a more relaxed relationship. Having a service dog is a huge adjustment because unlike with a pet dog it is with you constantly, including public places like restaurants, movie theaters, and stores. Although service dogs provide a lot of assistance (opening doors, picking things up, bracing, companionship) they also require a lot of work. Regardless of my energy level or the weather conditions, Fenn requires feeding, grooming, vet visits, walks, and bathroom breaks at work or social gatherings.

Although a caregiver or typical AT equipment could get the job done, Fenn provides the added benefit of constant companionship, eager assistance, and the social lubrication required for others to approach and converse with me. An assistance dog can be a rewarding experience; however, it is not a relationship to be approached lightly.

Ingrid C. Hendrix, MILS, AHIP, is the nursing services librarian at the University of New Mexico (UNM) Health Sciences Library and Informatics Center. She is also the library liaison to the UNM Occupational and Physical Therapy departments, where she teaches literature searching skills to students. She is working with Melissa Winkle and Dr. Terry Crowe at the University of New Mexico on an evidence-based review of the assistance dog literature and a research study examining functional outcomes for assistance dog owners.
Identifying and referring clients for assistance dogs

Evidence-based data is scarce regarding variables that affect successful placements. Although identifying appropriate human referrals is not yet an exact science, potential dog recipients should be evaluated regarding current abilities and needs; living and working environments that are conducive to a dog performing required tasks; and the demonstrated ability to care for, manage, and direct the dog. Working an assistance dog requires short- and long-term memory; skills with problem solving, sequencing, and generalization; a way to communicate to cue the dog; patience to develop a relationship with the dog; and the ability to both accept and respond to feedback. Other areas include financial ability for procurement costs and routine care for a dog if not provided by the organization; family and friends who understand and support the role of the dog; and the ability to attend the required placement training, which may involve traveling away from home for weeks at a time. Research has found that assistance dogs can exceed expectations in helping people to feel better, providing companionship, and meeting their needs; however, dog care, training, and traveling can be more difficult than anticipated. Lastly, for better or worse, clients should realize that having an assistance dog might call attention to their disability.

Other OT roles

Clients should be made aware of a variety of AT options so they can make informed decisions. If an assistance dog is the best option, practitioners can take an active role in preparing clients; helping to find funding; and making modifications to items such as gate latches, dog doors, feeding apparatus, commonly used tools (leashes, brushes, etc.), pegs on wheelchairs to hold a leash, and communication devices. They also can assist with establishing hand signals or establishing routines related to dog maintenance so that the person–dog team can meet the goal of independence. Practitioners also can become valuable team members for assistance dog training organizations because our services complement theirs.

Conclusion

Each type of assistance dog must meet specific training criteria to assist with tasks unique to their role, in addition to meeting the criteria established by each training organization. Therefore, the process of making referrals and offering assistance with placement should be an extremely client-centered, team approach. Dogs can offer assistance in many areas of occupation and across many environments, but they are not appropriate for everyone.

Melissa Y. Winkle, OTR/L, provides intervention services, national workshops, program development, and consulting through her private practice, Dogwood Therapy Services Inc., in Albuquerque, New Mexico. Her special interests include developmental disabilities, nature therapy, animal assisted therapy, and assistance dogs as assistive technology options. Under the guidance of Terry Crowe, PhD, OTR/L, FAOTA, at the University of New Mexico, she and Sue Zapf, MA, OTR, ATP, CTRS, are co-authoring the revisions to the Service Animal Adaptive Intervention Assessment, to help health care providers improve their ability to refer clients for assistance dogs as AT options. She is presenting at the Institute “Animal-Assisted Interventions: The Guiding Principles and Research” at AOTA’s Annual Conference & Expo.

Brooke D. Zimmerman, MOT, OTR/L, is an occupational therapist employed by Dogwood Therapy Services Inc. and Amedisys Home Health Care in Albuquerque, New Mexico, working with children, adults, and geriatric clients with a variety of cognitive and physical disabilities. She has co-developed and implemented animal assisted therapy programs within a skilled nursing/long-term-care facility and an acute psychiatric hospital, and has integrated programming at Dogwood Therapy Services Inc. Her special interest is intervention for people with cognitive and psychiatric disabilities through animal assisted therapy.

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Assistance Dogs International
www.assistedogsinternational.org/

International Association of Assistance Dog Partners
www.iaadp.org

FOR MORE INFORMATION
Can This Marriage Be Saved?

Nancy Mattei

This is my 25th anniversary as an occupational therapist. To take the analogy in the title further, I had had enough of my career as a modern dancer and fell in love with occupational therapy. And then, after 25 years of practicing, I found myself—as happens in many relationships—out of touch with my profession. What follows is an account of a way lost and then found.

Occupational therapy appealed to me instantly: its start in the Progressive Era, the philosophy of the “whole person,” recovery through activity, the history of service. The women founders were a source of pride. At the University of Illinois I became totally engaged with the science of occupational therapy and its human expression.

I was thrilled with my first job, at Mercy Hospital on the south side of Chicago, in the general medicine and surgery unit. The department had a strong foundation in occupational therapy philosophy. My fellow occupational therapists and director surrounded me with their sophistication and professionalism and further grounded me. (I've consciously withheld names—no one wants to be identified as participating in a messy marriage!) And then there were all the generous patients who trusted me. Thus my new life and work regime began. I identified hand therapy as a special interest and continued to develop skills and a certification. It was a fascinatingly technical field that I enjoyed immensely. I returned to the well many times over the years to learn new techniques and expand my knowledge. In time, I moved into more manual treatment with myofascial techniques and Travell’s trigger point treatment.

But looking back, I never took time to revisit the roots and the fundamental ideas of occupational therapy. I could still explain to patients the basic definition of occupational therapy, but I was out of touch with its deeper spirit. In becoming very technically proficient, I lost sight of the patient’s intrinsic ability to lead the way, direct the treatment, and heal. I was “fixing” patients.

Last summer I continued my studies with a craniosacral treatment class—seemingly very far from occupational therapy. As I was listening to the teacher talking about the patient-client relationship, the wholeness of the client, the inherent health of the client, and the balance between an active client and a listening therapist, I began to think back on my occupational therapy beginnings. I had heard all of this before.

This sent me back to a brief reading of the history of occupational therapy. During that reading, I came upon a Wilma West citation that intrigued me. I sourced the quote back to her 1967 Eleanor Clarke Slagle lecture, “Responsibility in Times of Change.”1 (I recommend you read the lecture in its entirety for its imaginative power in considering the future, as well as its challenge for action.) The following are her five main principles from the lecture:

1. Identify with the field of health, thus broadening our traditional identification with medicine.
2. Enlarge our concept of therapist to that of being a health agent responsible for normal growth and development.
3. Think more about roles in prevention as well as those in treatment and rehabilitation.
4. Think more about socioeconomic, cultural, and biologic causes of disease and dysfunction.
5. Think more about serving health needs of people in many settings other than the hospital.

West was no “New Ager.” She retired from the armed services as a major in 1968 after 20 years. She believed in the integrity of the whole person and the power of that integrity to achieve normal development and to heal. Our patients are larger than their pathology. They have all the resources and riches that come with being human beings. I knew this in my core 25 years ago but had lost touch.

Looking back, I have to admit I wavered in establishing the proper relationship “energy” with my patients. I was too intent on them getting better in a specific way that I valued. I had

A love letter to our history and profession

the information. I knew the research. I knew the anatomy. And although I did listen to them and I understood their goals, I didn’t inherently trust the natural process. I appointed myself the “fixer.” That role becomes an over-consuming task that can never be achieved.

My patients may have believed that I fixed them. Yet when I fell into that thought pattern, it didn’t serve them or me. (With all the exquisite techniques of the hand surgeons and hand therapists, it is understandable how we get into this.) When one “fixes,” the experience is framed in a very limited way. It gives too much of the authority to the “fixer.” It doesn’t allow an equal relationship based on trust in the ability of the patient to heal.

The patients with orthopedic conditions whom I have seen for the past 25 years haven’t come to me for some philosophical, intellectual, spiritual, or alternative experience. They have specific problems they want addressed. The healing of a bone is a very precise, intrinsic process. One offers each patient a very precise treatment to support the healing. How a therapist engages with the patient—the matrix of the experience; that is, the relationship—is just as precise as the cellular bone healing. That engagement has to be fine tuned to fit that particular relationship, on that particular day (I learned this as “therapeutic use of self”). Indeed one cannot separate the treatment and the matrix. This is the art of occupational therapy. As a former teacher said, “What is occupational therapy without that?” This explanation won’t fit into a code, it can’t be billed, but it is the spirit behind everything we do.

In her Slagle lecture, West cites the famous quote from Santayana: “He who neglects history will be condemned to repeat it.” May I amend this to say, “He who neglects history will not be able to repeat it.” We want to be able to repeat what we learned as young occupational therapists.

The idea: I’ve come back to the source that originally sustained me. I am grateful to a profession whose illustrous history and body of philosophy really explains the human condition. Grateful to all the men and women who made an invaluable profession out of ideas and dreams. (I can’t imagine health care without the profession of occupational therapy.) Grateful to the thousands of patients who have allowed me the privilege of being part of their lives in a meaningful way.

This is my love letter to our history and profession. I think this marriage can be saved.

Reference


Nancy Matti, OTR/L, CHT, has been practicing the art and science of occupational therapy for 25 years in the Chicagoland area.

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Working With Homeless Families

Winifred Schultz-Krohn

Families who are homeless and seek shelter at the Family Supportive Housing Program are referred to occupational therapy for a variety of reasons, including stress management, difficulties with problem-solving skills, and lack of family leisure pursuits. The shelter, located in Northern California, serves homeless families in which there is at least one adult over the age of 18 who is responsible for at least one child under the age of 18. This can include a mother and her children, two-parent families, grandparents and grandchildren, or aunts and uncles who are responsible for nieces and nephews. People who are homeless represent an underserved population that could benefit from occupational therapy services.1

Individuals within the family are sometimes referred for the following reasons:

- **Parents**: Services are provided to enhance and support parenting skills, financial management, work readiness, and home management to include the previously mentioned broader reason for referrals.

- **Children and teens**: To assess and foster appropriate developmental skills, decision-making skills, activities of daily living (ADL) skills, educational skills, and stress management.

- **Infants and parents**: To address parenting skills and enhance bonding, along with providing developmental screening and services to foster developmental skills.

As families enter the shelter, which can house up to 36 families at a time, they are provided with their own bedroom, access to shared bathrooms, and a dining area. All meals are provided by the shelter. The families are allowed to stay at the shelter for 3 months while the adults search for work, housing, and support services. Each family is assigned a case manager, who typically refers them to occupational therapy services, but self-initiated referrals also occur. The majority of occupational therapy services are provided at the shelter, but services are also offered to families through two programs after they leave the shelter (not all families participating in these two programs receive occupational therapy services). These two programs are directed by the Family Supportive Housing Program.

One program is Transitional Housing, in which financial support is provided on a decreasing basis over 2 years as families become more financially capable. The other program is Aftercare, in which families are followed for 1 year to support their ability to manage their finances in the community. The case managers evaluate each family’s needs and make recommendations for participation in one of the two programs. The managers of each program refer families to occupational therapy for several reasons, including difficulties with time and financial management, stress management, and decision-making skills. Services are typically provided on a consultative basis, either two or three times a month.

Most homeless parents experience depression and stress,2,3 which compromises their performance of ADL and instrumental ADL. Many of the parents have limited problem-solving and budgeting skills. With the loss of their home, many experience disenfranchisement from the general community, diminished social supports, and limited control over their environment. Homeless parents often have limited work experience, have lived in tenuous situations before becoming homeless, and have a history of mental health problems or substance abuse.4,5 Many do not have a high school diploma or equivalent, further limiting their access to well-paying jobs.

All of these factors compromise the ability of homeless persons to construct and engage in productive activities. Most experience a lack of energy and have difficulties prioritizing tasks. They often report feeling overwhelmed and unable to meet the demands needed to extricate themselves from being homeless. School-age children and teens have a high incidence of school absences, and frequent school changes during an academic year compromise their educational pursuits.

At this shelter, the most frequently used occupational therapy assessments are the Occupational Self Assessment (OSA)6 and the Child Occupational Self Assessment (COSA)7 because they facilitate the development of client-centered goals. Additional instruments, such as the Beck Depression Inventory8 and the Sensory Profile,9 or developmental screening tools such as the Denver Developmental Screening Test—II10 are also used as needed. Nonstandardized assessments, such as interviews,
are used for each client to further evaluate individual occupational needs.

To determine client goals, we explain the process of occupational therapy services, including the standardized assessments or interviews. The OSA and COSA allow clients to identify important occupational pursuits, then we establish specific outcome goals through the interview process. For example, an item from the OSA such as “accomplishing my goals” would be operationally written to reflect a specific outcome, such as complete three job applications to secure employment. This process provides a common agreement between the client and therapist about what needs to be addressed during the session and reasonable time frames to meet each goal. Evaluation reports are generated for the initial session, and notes are written using a SOAP (subjective, objective, assessment, plan) format. The most typical challenge is scheduling and addressing all the needs of clients. We address this challenge by helping clients prioritize their concerns and by focusing on what issues are most important for them while they are living at the shelter.

After the goals are determined, intervention includes evaluating the status of the goals and working on the systematic skills needed to accomplish them. The client and therapist work together on a task, then the therapist provides exercises or activities to be accomplished before the next session. For example, securing employment often requires developing interviewing skills and anticipating questions from a potential employer. During a session the client and therapist may engage in these practice opportunities to reflect a specific outcome, such as helping children with the words they can use to ask for assistance or to engage in play with peers, or working with parents on basic sequencing skills before they begin searching for a job. Many parents have identified a need to express themselves more clearly. During the occupational therapy sessions we practice using basic vocabulary words that will clearly express their concerns and interests and then apply those skills during practice job interviews. Parents have reported that engaging in these practice opportunities has been very helpful during the actual job interview.

The clients we serve have demonstrated improved performance related to desired occupational areas. For example, children display better frustration tolerance and have increased opportunity to play with peers during group occupational therapy sessions, teens have increased opportunity for inexpensive leisure pursuits to mitigate the deleterious effects of being homeless, and parents learn positive parenting techniques and engage in leisure activities with their families.

One of the biggest problems of serving homeless families is that they are very transient and frequently leave the shelter before completing the program. Although most of the families stay at the shelter for the 3-month period, the need to secure housing and employment takes a priority over occupational therapy appointments, which are often cancelled or missed. Therefore we run several groups each day to provide services for children, teens, and parents, to give them multiple opportunities to participate.

We face significant funding issues and are investigating alternative ways to support occupational therapy services with this population. Currently, these occupational therapy services are provided by graduate fieldwork students. I train and supervise the interns and provide my services on a pro bono basis. The population of homeless families is underserved, and occupational therapy provides a much-needed support. Occupational therapy service should not be driven only by a diagnosis, but should be provided to meet an occupational need. The engagement in occupation, the cornerstone of the profession, is important for all persons, including those who are homeless.

References

Winifred Schultz-Krohn, PhD, OT/L, BCP, SWC, FAOTA, is a professor of occupational therapy at San-Jose State University. Her scholarly interests include pediatric occupational therapy with expertise in school-based practice and family centered intervention, the needs of children and families in homeless shelters, multicultural health care issues, feeding problems, and neurological rehabilitation. She is the co-editor of the 6th edition of Pedretti’s Occupational Therapy: Practice Skills for Physical Dysfunction textbook. She serves on the editorial board of the Occupational Therapy Journal of Research and the Journal of Occupational Therapy, Schools & Early Intervention.
A recent article reported the results of an exploratory study that examined the experiences of occupational therapists being in a supervisory role during students’ fieldwork experiences. The author made a point of stating that there is little published evidence in the occupational therapy literature that addresses fieldwork education. I could not agree more; there is an abysmal lack of research being published related to occupational therapy fieldwork education at a time when our profession is emphasizing the need to produce more evidence for what we do. Why is investigational research in this area so important? Because supervision in fieldwork is as much an intervention as are treatment interventions being provided in the clinic. And, as stated in the study, “A theoretical perspective about supervision helps make sense of the experience, attempts to account for changes in student learning, and can help validate and direct effective clinical practices within the profession” (p. 156).

Not since 1998 has there been a publication that focused on fieldwork and examining outcomes. The Fieldwork Anthology: A Classic Research and Practice Collection devoted three of the seven sections to research on fieldwork education. A literature search using the bibliographic tool OT Search yielded a listing of 734 articles published on “fieldwork education,” but only 36 articles were found when the search was changed to “research on fieldwork education,” and only 19 of these were published in the 11 years since the fieldwork anthology was published. Of the few articles published on fieldwork research, many were written by our colleagues in Canada, Australia, New Zealand, and the United Kingdom. Occupational therapy fieldwork educators and academic fieldwork coordinators in this country have the broad-based knowledge and skills to produce this kind of research and could partner with academic faculty and students to design and implement these kind of studies. There are several fieldwork consortia in the U.S. that could collaborate on some identified research questions on fieldwork outcomes. In the absence of an established consortia, educational programs and fieldwork sites could collaborate to produce a broader database of fieldwork information, since there are probably regional variations across the country. I am listing some ideas for research questions that can be explored below and I encourage the readers of this column to identify others:

- What are the outcomes related to the sequencing of fieldwork in educational programs curriculum design? Some programs schedule all Level II fieldwork experiences after coursework has been completed, whereas others schedule Level II fieldwork experiences throughout the curriculum—is there a difference?
- The American Occupational Therapy Association recently launched a Certification Program for Fieldwork Educators. How do outcomes relate to the training that fieldwork educators receive?

These and many other topics could be identified and pursued in occupational therapy and occupational therapy assistant programs across the country. Many of these topics would be ideal for master’s theses and doctoral dissertations. Reviewing articles in other countries’ occupational therapy journals can give us ideas about research studies that could be replicated. Let 2009 be the beginning of our response to a Call for Research on Fieldwork Education.

References

Donna M. Costa, DHS, OTR/L, FAOTA, is a clinical professor in the Occupational Therapy Program at the University of Utah in Salt Lake City. She is the author of Clinical Supervision in Occupational Therapy: A Guide for Fieldwork and Practice published by AOTA Press.
References


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Earned doctorate, certified as an Occupational Therapist, credentialed, or eligible for credentialing, as an occupational therapist in the state of Michigan; a minimum of six years’ experience in the field of occupational therapy, including practice as an occupational therapist; administrative or supervisory experience; at least two years of experience in a full-time academic appointment with teaching responsibilities; evidence of excellence in teaching, academic or clinical publications, and professional/clinical service to meet university standards for the faculty rank of Associate or Full Professor.

Responsibilities:

Tenure track, FY appointment as chief academic and executive officer, reporting to and advising the dean regarding the department. The chair engages in teaching, research, or clinical activities; promotes shared governance; is responsible for effective administration of the department; and provides leadership and direction regarding:

• Planning, developing, delivering, and assessing academic programs
• Maintaining excellence in faculty teaching and supporting a student-centered culture
• Fostering scholarship and externally funded research
• Hiring, developing, and reviewing faculty and staff
• Planning and managing the department budget and other resources
• Managing student enrollment and retention with emphasis on academic excellence and diversity
• Developing and maintaining community partnerships
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• Fostering collegiality and good morale

Department: The Occupational Therapy Department was founded in 1922 and has the distinction of being the first non-teacher education academic program at WMU. The program has been ranked as the best occupational therapy program in Michigan by US News and World Report, 2008. The department admits 60 students into the Kalamazoo campus, and is in the process of implementing a satellite program at the University’s Grand Rapids campus. The department has 10 faculty members with 8 holding a doctorate degree. The faculty has an outstanding record of research, publication, and receiving external funding.

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By Carolyn M. Baum, PhD, OTR/L, FAOTA, and Dorothy Edwards, PhD
Photography by Madelaine Gray, MA, MPA, OT, and Stephanie Cordel

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By Roxie M. Black, PhD, OTR/L, FAOTA, and Shirley A. Wells, MPH, OTR, FAOTA

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OT PRACTICE • MARCH 23, 2009
Jennifer Coyne, BHS, COTA/L, is the program director for the occupational therapy assistant program at Greenville Technical College in Greenville, South Carolina. Here, she talks about being one of the first occupational therapy assistants to become a program director in the country, and her participation on the Commission on Education (COE) for the American Occupational Therapy Association (AOTA).

**Q How did you become the OTA program director at Greenville Technical College?**

I started out teaching kinesiology as an adjunct instructor in 2004. After teaching at Greenville Technical College for one semester, they offered me a full-time position as the academic fieldwork coordinator. I loved that job, marketing and placing students in fieldwork rotations. After I had been a full-time faculty member for 1 year, the program director resigned. While the college interviewed candidates for the position, I was named interim program director. I was responsible for the all encompassing duties involved with the daily operation of an OTA program. It was overwhelming at first, but I soon found myself enjoying, and even loving, each and every challenge that surfaced. When the new ACOTE standards were put into place, it made it possible for an occupational therapy assistant to be a program director. Due to the new standards, my role as interim program director has evolved into the program director.

It never occurred to me that I might be one of the first occupational therapy assistant program directors. Upon this realization, I became extremely excited about the future and what this new role may bring for me as well as all OTAs. I am thrilled that the new standards allow OTAs the opportunity to become involved in management positions in the academic arena.

**Why is it important for OTAs to be program directors?**

I think it is important that ACOTE now allows occupational therapy assistants to be program directors, because we know exactly what occupational therapy assistants should do. I have been an occupational therapy assistant student and clinician, and feel like my experience benefits the occupational therapy assistant program greatly. When you have an occupational therapy assistant in the program director role, you understand what entry-level practice is for an occupational therapy assistant. That is not to say that an occupational therapist does not understand entry-level practice for an occupational therapy assistant. I just think that sometimes the understanding of entry-level expectations for the OTA can be skewed due to the fact that they are different from entry-level expectations for an OT.

I think it is also important for AOTA, and other organizations that support occupational therapy assistants, to encourage OTAs to take on leadership positions. The new ACOTE standards opened the door for this to happen. To meet the Centennial Vision of AOTA, it is imperative that occupational therapists, as well as occupational therapy assistants, are active in state and national professional associations.

**How did you get involved with COE?**

I attended the OTA Forum at AOTA’s Annual Conference, and heard there were only a very small number of occupational therapy assistant members of AOTA. I was really shocked and disappointed. I decided to get more information about AOTA out to my students, in hopes that it would spark greater interest in them. During this time, I began paying closer attention to the 1-Minute Update from AOTA, and happened to see an opening on COE [Commission on Education]. They were looking to fill several positions, one being the occupational therapy assistant educator position. Honestly, I never considered taking on a leadership role in AOTA prior to learning of this opening, but I decided that my involvement was necessary. If I am expecting my students to become AOTA members and take on leadership roles, then I should not just talk the talk, but also walk the walk. It was a very exciting day in 2007 when I was appointed. It is a 3-year appointment, and I am the only educator on the commission who is an occupational therapy assistant.

**What advice do you have for other OTAs who want to get involved in leadership?**

My suggestion is to make sure you are a member of AOTA! If you are not a member of AOTA, then you really do not know where the heart of things are for occupational therapy practitioners. I am constantly encouraging my students and practitioners in the community to get involved with AOTA and the state occupational therapy association. I think people wait for opportunities to come to them rather than taking the step forward themselves. I encourage OTAs to step forward, and take the initiative to see what they can offer.

Jennifer Coyne can be reached at Jennifer.Coyne@gvltec.edu
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Using Theory and the Therapeutic Reasoning Process To Guide the Occupational Therapy Process for Older Adults With Mental Illness

LISA MAHAFFEY, MS, OTR/L
Occupational Therapist, Linden Oaks At Edward, Naperville, Il

This Continuing Education Article was developed in collaboration with AOTA’s Mental Health Special Interest Section.

ABSTRACT
Studies have shown the importance of engaging in meaningful occupation to achieve and maintain good mental and physical health (Clark et al., 1997; Rowe & Kahn, 1997). This article lays out a six-step reasoning process that is compatible with any occupational therapy theory. Using this process, the practitioner makes decisions throughout the occupational therapy process that incorporate the concepts of the chosen theory. The result is intervention that is occupation-based, client-driven, and meaningful to older adults who are hoping to gain satisfaction in their lives in spite of physical or mental challenges.

LEARNING OBJECTIVES
After reading this article, you should be able to:
1. Recognize the transactional relationship between participation in occupation(s) and the mental health status of older adults.
2. Recognize a therapeutic reasoning process that structures decision making during occupational therapy intervention when using a theoretical framework.
3. Recognize how applying a therapeutic reasoning process using a theoretical model like the Model of Human Occupation (MOHO) can direct intervention toward meaningful and fulfilling occupations for older adults.
4. Recognize how the therapeutic reasoning process is compatible with many theories that are appropriate for working with older adults.

INTRODUCTION TO MARIAN
Marian is admitted into the geriatric mental health unit for the third time this year. During the last two hospitalizations she was suicidal and difficult to motivate. This time, she has too much energy and had been staying up most of the night cleaning. Marian is 78 years old. She was diagnosed with bipolar disorder in her 20s. She was put on medication and had a long period of stability during which she was able to raise her kids, complete a degree in business management, and run her own gift shop. Three years ago her husband became ill. Marian cared for him until his death last year, then fell into a deep depression from which she has not been able to recover.

Mental Health and the Older Adult
Occupational therapy practitioners work with seniors in many different settings, thus we need to be prepared to address mental health issues among this population. The latest report on mental health prepared by the Surgeon General (U.S. Department of Health and Human Services [DHHS], 1999) estimated that 20% of older adults are diagnosed with a mental illness. Many people go without interventions that would allow them to live an occupationally rich life. Between 2018 and 2032, the population of older adults will double (CDC, 2007), and if trends continue, so will the number of those needing mental health support.

Because of the stigma of mental illness, and the fragmented and disconnected U.S. health care system, many older adults with mental illness fall by the wayside. Many do not seek help from a psychiatrist, opting instead to see their primary care physician (National Institute of Mental Health [NIMH], 2007). Sixteen percent of all suicides are among adults over age 65, although people in this age group comprise only 12% of the total population (NIMH, 2007). Seventy five percent of these older adults visited their primary care physician within a month of their suicide (NIMH, 2007). On the positive side, more mental health facilities are working to cater to the needs of older adults. There has been a recent push for more community-based mental health services, starting with educating primary care physicians to recognize and treat the symptoms of mental illness (Krahn, 2006). The Substance Abuse and Mental Health Services Administration (SAMHSA, 2007) and geriatric psychiatric units are developing programs that can address more severe situations. Occupational therapists are in a position to identify the need for mental health support in home health, rehabilitation settings, and long-term-care facilities.

Statistically, only 5% of community-dwelling older adults have depression. However, that percentage rises to 13.5% among those requiring long-term health care. And depression is not the only mental health concern. Two thirds of people living in extended care facilities meet the criteria for a psychiatric diagnosis (NIMH, 2007). Overall, 10% to 12% of older adults are at risk for alcohol dependence, 1% are diagnosed with bipolar disorder, 11% are diagnosed with anxiety disorders, and 1% are diagnosed with schizophrenia (DHHS, 1999).

The prevalence of depression increases when people have other illness or injury (Miller, Paschall, & Svendsen, 2006), and the reverse can also be true. Incidences of dementia, heart disease, diabetes, and possibly cancer increase when depression
in older adults is left untreated (Miller, Paschall, & Svendsen, 2006). For example, when an older adult has a serious fall, fear of another fall can keep the person from going out and engaging in meaningful occupations. This lack of activity often leads to catastrophic loss of roles, social connection, and physical conditioning, resulting in isolation, depression, and an increase in the chances of having another, potentially more devastating fall (Centers for Disease Control & Prevention, 2008; Holland, Peterson, Levin, Ried, Pordon, & Bak, 1993). In addition, people who struggle with recovery from injury or illness often take multiple medications. “Do The Right Dose” is a new initiative from SAMHSA in response to increasing numbers of older adults who are misusing medications, using alcohol with their medications, or seeking help for new addictions. SAMHSA also is addressing the growing incidences of accidental overdose due to confusion (SAMHSA, 2006).

Faced with these statistics, it is hard to remember that mental illness is not a normal part of aging. The majority of older adults cope successfully with the changes in their bodies and the losses that come with getting older. Researchers have attempted to determine what factors contribute to these persons’ ability to successfully cope with aging. Rowe and Kahn (1997) identified several factors, including level of education and continuing education, as strong indicators of the ability to cope with aging. Other factors include having a support network, being engaged in daily life (particularly in productive activity), and having a sense of control over one’s life and a say in major life decisions.

The Well Elderly Study completed by researchers at the University of Southern California is a defining study for the power of occupation and occupational therapy intervention (Clark et al., 1997). Participants from several independent living situations were divided into three groups. One group received no intervention, one group was encouraged to attend social activities, and one group received both group and individual occupational therapy sessions. The subjects in the occupational therapy intervention group were taught the importance of continued participation and were given skills to stay active in occupations, such as managing changes in nutritional needs and avoiding falls. Individual sessions helped them apply the lessons to their own situations. All participants were administered a battery of five assessments that measured physical and social function, self-rated health, life satisfaction, and symptoms of depression, before and after the intervention. Both control groups showed a decline in all indicators. The intervention group showed improvement in all indicators except three, and declined significantly less in those. The results provide strong support for making participation in occupation the desired outcome of occupational therapy intervention.

THE ROLE OF THEORY IN PRACTICE

It is occupation-based theory that sets occupational therapy intervention apart from interventions used by counselors, physical therapists, and others who provide care to geriatric clients. As a clinical supervisor for students from schools all over the country, I have noticed that theory remains an afterthought and is not a guide in determining the course of intervention. Occupational therapy theory must be used to guide intervention, from the moment the person enters our care. By using theoretical concepts to guide information gathering and intervention, not only do we focus on participation through engagement in occupation (AOTA, 2008), but we also have the words and language to help others understand and value our unique contribution to a person's recovery.

Theory and the Reasoning Process

Mattingly (1991) used an anthropologic approach to study and describe the way occupational therapy practitioners think when engaged in the process of intervention. Kielhofner and Forsyth (2008), building off of Mattingly’s approach, proposed a six-step process that helps the practitioner “think with theory.” This reasoning process can be used with all theories, including those that are not traditionally used in occupational therapy practice. The six steps of the therapeutic reasoning process structure practitioners’ choices from the moment they are introduced to their client until discharge. Kielhofner and Forsyth used the Model of Human Occupation (MOHO) to illustrate this process. The remainder of this article will use the MOHO as the framework to demonstrate how to integrate theory as a guide to intervention.

The six steps are as follows:

**Step One:** Generating clinical questions based on the concepts of the theoretical model.

**Step Two:** Collecting information from the person, through formal and informal means.

**Step Three:** Creating a picture of that person’s experience.

**Step Four:** Working with the person to generate the intervention plan, including goals and strategies.

**Step Five:** Implementing the plan.

**Step Six:** Evaluating the outcomes.

It is important to remember that the steps are not necessarily followed in this order. Practitioners often complete the steps concurrently as they move through the process. The choice of which theory to use in the process may be a reflection of the treatment setting, the age of the client, the presenting problem, or the therapist’s preference. It is also important to keep in mind that the process is taught to clients when possible, so they gain competence in making changes in their own lives after being discharged from therapy (Kielhofner, 2008).

In Marian’s case, the MOHO (Kielhofner, 2008) will be used to develop the clinical questions and drive the therapeutic reasoning process. The MOHO begins with the understanding that people are occupational beings and that our identity and sense of effectiveness in the world are established through successfully participating in our roles, identifying what motivates us, and developing our competence in occupations. Performance
factors such as our neurological and mental capacity, our natural and learned functional skills, and our developed interpersonal skills, are key to successful participation. MOHO also considers the transactional relationship between the person and the contexts in which he or she lives, learns, and works (Kielhofner, 2008).

MARIAN AND THE THERAPEUTIC REASONING PROCESS

When Marian was admitted into the mental health facility, the information in her chart focused on her symptoms, her recent history of frequent hospitalization, her children’s concerns, and her advancing age. Her children were worried that Marian’s mental status meant they could no longer care for her, and they sought options. Further discussion with two of Marian’s children revealed anxiety about her memory. She was calling them more frequently and not remembering the previous calls. She was losing things more often, and she was not able to remember how to get to her daughter’s new home. As part of her inpatient treatment, Marian was referred to occupational therapy.

Step One: Generating Clinical Questions

The first step in the therapeutic reasoning process is to generate a list of clinical questions. The clinical questions are based on the tenets of the theory, which helps to focus and guide the method of information gathering, the choice of instruments, and the quality and focus of the information. A list of clinical questions can be found in the fourth edition of A Model of Human Occupation: Theory and Application (Kielhofner, 2008 144). I considered the following questions to be most important in guiding Marian’s treatment when I first made contact with her.

- **Occupational Identity:** How does Marian describe herself occupationally? What factors have influenced her view of herself and her lifetime of participation? What has been most motivating for her throughout her life?
- **Occupational Competence:** Does Marian feel she has been able to meet her past responsibilities and accomplish her goals? Does she feel she has the ability to accomplish the tasks she needs and wants to do now?
- **Habituation:** What is Marian’s daily routine? Does it reflect those things that motivate her? What roles does she identify with, and does she feel that she meets the expectations of these roles? Is she routinely engaging in productive, leisure, social, and self-care activities?
- **Performance and Skill:** Are there factors that are interfering with Marian’s ability to participate in self-care and productive, leisure, and social activities? Does she have the motor, process, sensory modulation, and communication and interaction skills to participate in her occupations?
- **Volition:** Is Marian able to express confidence in her ability to engage occupationally? Does she feel that she has control in her daily routine? What does she identify as most meaningful, and is she incorporating activity with meaning into her daily routine? Is she able to identify direction for her life given the changes she has experienced?

- **Environment:** What sort of support will Marian need to remain at home? Are there those supports available in her community? Does she have the transportation and monetary supports to stay active and meet her role expectations? Are the supports in place if she shows increased signs of cognitive decline? Do Marian and her family understand her bipolar disorder and dementia so as to be able to monitor changes and react in her best interest? Are she and her family aware of the care options, and can they access that system?

Although additional questions may surface during the evaluation and intervention stages of care, starting with these allows me to create a narrative of Marian as an occupational being who interacts within the context of her home, community, and social relationships.

Step Two: Collecting Information

Step two of the therapeutic reasoning process is gathering information. Decisions about what assessments to use are based not only on the questions I have posed, but on Marian’s age and developmental life stage. Interview is always a source of information, and I find the Occupational Performance History Interview (OPHI) (Kielhofner, et al., 2004) to be a good choice for older adults. The OPHI is semi-structured and designed to capture a person’s life story, focusing on engagement in occupations throughout the life span. The OPHI covers many of the clinical questions and can pinpoint changes in occupation that are characteristic of changes in physical or mental status, many of which lead to admission to a mental health facility. In addition to interview, I will use self-report forms, observation, and, if needed, a more formal cognitive assessment such as the Allen Cognitive Level Test (Allen, 1990).

In my experience, older adults enjoy having someone to talk with, but asking a lot of questions at once can be overwhelming and uncomfortable. Keeping the clinical questions in the back of my mind allows me to gather information every time Marian and I are together.

Initially, Marian expresses anxiety at being in the hospital and talking about herself. She does better with a series of short question-and-answer sessions over several days. She is also more willing to share in groups when she experiences others sharing. The evaluation process continues as I spend time on the unit, during morning activities of daily living time and meals. By helping Marian and others complete these tasks, I have the opportunity to unobtrusively observe them. She is also observed interacting with her peers and staff, during groups and in the milieu. The observations are meant to identify her motor and process skills, such as her ability to manage her utensils and tray, adapt to changes, learn from her mistakes, etc. (Pan & Fisher, 1994). Eventually, she becomes more active and interested in the assessment process and in setting goals for herself. I ask her to complete a Role Checklist (Oakley, Kielhofner, Barris, & Reichler, 1986). This simple
Marian's story. Challenges. I return to the clinical questions noted earlier to develop Marian's story.

Occupational Identity: Marian struggles with describing herself occupationally. She is quick to mention being a parent and grandparent, but her children are busy and she knows that these roles are not enough to occupy her time. She also identifies owning her own home, but feels that is in jeopardy due to her struggles to keep it up. She falls back on her long history of participating in her life roles to characterize herself. Difficulty staying on task and constant feelings of self-doubt affected her school years. Shortly after turning 20 she had her first manic episode and left college to open a business on the West Coast, spending all of her money and borrowing from questionable sources. In her late 20s she was placed on lithium and began to experience a period of stability that allowed her to complete a business degree and open her own gift shop. She met her husband at this time and credits him for much of her stability. “He was always supportive, and if he saw my moods shift, he would encourage me to take care of myself,” she says. They raised five children. One daughter is diagnosed with bipolar disorder and remains stable. Her son lives in California and has an addiction to alcohol. Although he was never diagnosed, Marian is convinced that he too has bipolar disorder. They have remained estranged, and this is a constant source of sadness for Marian. The four children in the Chicago area have been supportive and available to Marian. Marian describes her grandchildren as her “greatest joy.” She gave up the role she took most pride in, owning and managing the gift shop, when her husband became ill. For the 2 years that she took care of him she rarely got out. Although the kids offered to help and regularly relieved her so that she could shop and run errands, she felt it was her responsibility to care for her husband and she didn’t want to bother them. Because of this, she lost touch with her friends and gave up most of her interests. She has not had the motivation to reconnect since her husband died.

Occupational Competence: Marian talks with pride about her life. She sees herself as overcoming her bipolar disorder to accomplish her goals. Several times she reflects on her relationship with her son, or her “episode” in California, but for the most part, she is able to focus on the things she is proud of. When the conversation turns to the present, she becomes much sadder. She worries about her memory and struggles with how she will ever get the motivation to re-engage. Her recent “burst of energy” was encouraging to her until her children brought her to the hospital. Although she is able to see that there were unhealthy patterns, such as spending too much money, she remains unsure that this behavior was a symptom of mania and wonders if the children are just trying to take control of her. Marian identifies exercising more and cleaning the basement as her goals. When asked about how she would fill the remainder of her time, she is unable to identify anything, stating that she is too old and too tired to do anything else.

Habitation: After Marian’s husband died, her days were characterized by watching TV. She would get microwaveable meals for herself, but there were long periods when she didn’t eat anything. She would shower and dress on days her family was coming; otherwise, she would put on clean pajamas and spend much of the day on the couch. She did clean when she had the energy, but it didn’t take long. She was sure the house needed repair but was content to leave that to her children. The week before she was admitted, she was averaging 3 hours of sleep per night and was spending hours cleaning the attic and the basement. She could not focus on anything, and as a result she left the house in chaos, which was weighing on her mind. Marian conceded that the greatest period of stability in her life was when she owned the gift shop and had to get there each day. She realized how much she missed the interaction with customers and the creative process of arranging the store displays and windows. A friend had always been understanding of her mental illness and had provided her with support at some of the more trying times. Marian realizes that this friend would help her reconnect with her social network so that she won’t need to rely so heavily on her children.

Performance and Skills: Marian’s loss of major roles—owning a gift shop and providing care for her husband—has been a powerful factor in her sense of identity and her participation. Her grief encompasses these losses, along with her husband’s death. She appears to have had good communication and social interaction throughout her life. Of concern now is her memory. Marian shows minor difficulty with task management. The first few days she took the wrong meal tray and when it was pointed out, expressed frustration with the system. During activities of daily living (ADL) she struggled with finding her things. By day 3, Marian is able to remember where her

**STEP 3: CREATING A PICTURE**

In step three of the therapeutic reasoning process, a picture of the person is created, including his or her strengths and challenges. I return to the clinical questions noted earlier to develop Marian’s story.

Occupational Identity: Marian struggles with describing herself occupationally. She is quick to mention being a parent and grandparent, but her children are busy and she knows that these roles are not enough to occupy her time. She also identifies owning her own home, but feels that is in jeopardy due to her struggles to keep it up. She falls back on her long history of participating in her life roles to characterize herself. Difficulty staying on task and constant feelings of self-doubt affected her school years. Shortly after turning 20 she had her first manic episode and left college to open a business on the West Coast, spending all of her money and borrowing from questionable sources. In her late 20s she was placed on lithium and began to experience a period of stability that allowed her to complete a business degree and open her own gift shop. She met her husband at this time and credits him for much of her stability. “He was always supportive, and if he saw my moods shift, he would encourage me to take care of myself,” she says. They raised five children. One daughter is diagnosed with bipolar disorder and remains stable. Her son lives in California and has an addiction to alcohol. Although he was never diagnosed, Marian is convinced that he too has bipolar disorder. They have remained estranged, and this is a constant source of sadness for Marian. The four children in the Chicago area have been supportive and available to Marian. Marian describes her grandchildren as her “greatest joy.” She gave up the role she took most pride in, owning and managing the gift shop, when her husband became ill. For the 2 years that she took care of him she rarely got out. Although the kids offered to help and regularly relieved her so that she could shop and run errands, she felt it was her responsibility to care for her husband and she didn’t want to bother them. Because of this, she lost touch with her friends and gave up most of her interests. She has not had the motivation to reconnect since her husband died.

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things are and to manage all of her self-care tasks independently. She continues to need help finding her way outside of the unit. Her first visit to the cafeteria proved to be very anxiety provoking, but that anxiety subsided with subsequent visits.

Marian completed neuropsychological testing while at the hospital. Results indicate that she has Alzheimer's-type dementia. Her ability to use visual cues for memory recall to use judgment indicate that she is in the early stages. She is placed on medication to slow the progression of the disease. This development will need to be considered in all discharge decisions, client and family education, and the occupational therapy intervention and discharge plan.

**Volition:** Marian completed the OSA with great interest. She identified several problems, but the areas that are most important to her are reconnecting with her social supports and finding things to do that give her a sense of purpose. She uses the results of the OSA to identify three goals: (1) to find part-time work or volunteer somewhere so she can feel productive, (2) to reconnect with her friends and re-engage in the activities they once did, and (3) to improve her health and fitness by eating healthier, managing her medications better, and adding activities, including exercise at the YMCA. She expresses some fear over returning to the gift shop as an employee and not the owner. She identifies being with children as a joy and is sad that she has so little time with her grandchildren. Marian decides she would like to explore opportunities where she could work with children. Her diagnosis of Alzheimer's-type dementia and the implications of the disease process anger her because she has managed her bipolar disorder, and now she has to contend with this. She agrees that she will need to put things into place to accommodate the inevitable changes in her mental status.

**Environment:** By the end of Marian's hospitalization, it is determined that she will be able to return home for the time being. Her memory problems remain, but her judgment is intact and her function clearly improved as she became familiar with her surroundings. She will be allowed to drive in her local and familiar community but agrees to ask for help to go somewhere outside of her community. The family is made aware of a driving assessment program they may use if the need arises. The gift shop and several volunteer options are available near her home. In fact, she could walk to the gift shop and the local elementary school, where there is an opportunity to read to children. One daughter lives in her town with her two teen girls, and the three of them agree to check in on Marian every day and to fill her pill box on Sundays. The other children agree to take on other roles, such as home maintenance. Marian is hesitant to give up control of her money, so a system is established to include one daughter on the account. Marian will be given cash for the week, but the bank or her daughter will handle all other monetary responsibilities. They have discovered that Marian can use her cell phone to record appointments and her medication schedule, and it will beep to remind her of these things. Marian got in the habit of carrying her phone when her husband was sick, so this will serve as her lifeline. A neighboring community has a support group for people with bipolar disorder, and a local assisted living facility has a support group for people dealing with Alzheimer's disease. The family is given this information and encouraged to tap into these resources. Lastly, Marian is introduced to the idea of moving into assisted living. She and her family agree to explore the assisted living facilities near them.

**Steps Four and Five: Generating Goals and Implementing a Plan**
Step four in the therapeutic reasoning process is identifying goals, and step five is implementing them. Because of the client-centered nature of the MOHO, Marian is able to identify her own goals, which will guide mine. The evaluation process gives her the opportunity to explore her occupational history and identify the things that have supported her success. The results provide her with direction for the future. Marian's occupational therapy goals are to arrange to return to the gift shop and to volunteer in order to regain a sense of control and to explore and understand the changes in her cognitive status, which will require modification for future occupations. Implementation for Marian is simply a matter of providing her with the resources she needs to explore her community, setting up opportunities for her to discuss her goals with her family and friends, and keeping her discharge plans achievable. Marian also appreciates the frank discussion about her Alzheimer's diagnosis and the need to have a plan for her future. Although her situation is distressing at times, she likes the idea of being proactive and having a level of control in future decisions.

**Step Six: Evaluating Outcomes**
The last step in the process is evaluating outcomes. In a short-term, acute hospital stay, this process can only focus on the person's function within the hospital. However, many of Marian's goals are achievable only after discharge, and I will not be able to follow up with her after she is gone. Marian expresses a greater sense of self-control and comfort now that she has direction and some things to look forward to. She feels much more hopeful, and her fear is under control. Her family states that they also have a better idea of how to help her.

**CALEB AND THE THERAPEUTIC REASONING PROCESS**
Using an approach focused on participation creates opportunities for setting meaningful and functional intervention goals with someone who has more advanced dementia. Using the MOHO, the practitioner focuses on participation in valued roles as the end goal, with adaptation for cognitive challenges as needed. Caleb came to the hospital diagnosed with Alzheimer's disease. He was living at home with his wife and one daughter who had recently moved home to help her mother care for him. Caleb had recently taken to wandering off. When his exit is blocked, he becomes aggressive, and he has threatened to hit his daughter several times. He was
brought to the hospital to help decrease his aggression and to be evaluated for placement. Caleb proves to be challenging to the staff and other patients on the unit. He wanders from door to door asking to be let out. He becomes frustrated and angry, banging the doors and shouting.

The occupational therapy evaluation is developed around a similar set of clinical questions as Marian's, although with Caleb the focus shifts to his past participation and what made up his occupational identity throughout his life. The evaluation with Caleb is ongoing because each conversation presents new information. Caleb's wife and daughter are very helpful, providing me with information about his past occupations.

**Caleb's Evaluation**

Caleb spent much of his adult life working at a factory that built electronic parts for radios and television sets. Eventually he worked his way up from the floor to plant manager, where he was in charge of production and labor. The company was relatively small and he took pride in knowing everyone who worked for him, taking great responsibility for their well-being. Before working at this company, he spent 2 years in the army and saw action in Korea. He never talked about this with his family but alluded to something terrible happening there. He met his wife after he got out of the army, and they have been married for 53 years. They had two daughters and a son. About 11 years ago, their son died of cancer. Caleb rarely talks about his son despite their having been close when he was alive.

**Using Other Theoretical Models in the Therapeutic Reasoning Process**

When working with clients like Caleb who have dementia, I like to incorporate other theories and models into the therapeutic reasoning process. In addition to MOHO, I draw on two other theories related to dementia that work well with occupational therapy. The first, by Barry Reisberg and colleagues, is called **Retrogenesis** (Reisberg et al., 1999). Retrogenesis states that people with Alzheimer's disease will regress cognitively in the same pattern and time frame as infants and children develop. One of my clinical questions is, “How does Caleb manage self-care tasks such as getting dressed and eating?” I can compare the results of my observation to the stages of child development, and by doing so I am able to consider interventions that help him feel more in control. Caleb no longer effectively uses utensils when eating, often trying to use his knife to eat soup or to stab a piece of meat. After many battles the family opted to feed him, which he tolerates poorly. During his stay, Caleb and his family are introduced to the idea of finger foods. By using his fingers to put food in his mouth, Caleb is able to feed himself independently. As a result, he is calmer at meals and his intake has improved significantly. Caleb also has difficulty with continence and tends to relieve himself in a corner. At first the staff puts briefs on him, but changing them proves challenging because Caleb becomes aggressive. Although he keeps the briefs on at night, he is eventually put on a toileting schedule and taken to the bathroom every 2 hours, where he manages with moderate assist and little aggression.

Another theory I draw from is **Validation Therapy** (Feil, 2002). Naomi Feil, MSW, developed this theory after observing how her interaction with older adults affected their happiness and their distress and unresolved grief to the staff, and over time these memories become less emotionally charged. Treatment includes exploring ways to engage Caleb in tasks associated with successful past roles. His family is included in this process so regardless of their stage of dementia (Feil, 2002). As care providers, it is often our job to understand the purpose behind a person's actions. When using Validation Therapy, clinical questions are created to explore the relationship between past occupational participation and current emotional response to daily situations.

Caleb struggles with self-care on the unit. In my attempt to solve this problem, I implement a validation process with him. At one point Caleb decides that I am a reporter doing an exposé of the war, and he begins to share what happened. Although he never gives details, he alludes to being awakened early in the morning, stripped, and made to do humiliating things. The staff decide that this memory may be why he is so resistant to self-care. After changing his bath time to early evening, they find that he is much less distressed. Validation therapy reveals that Caleb experiences time as nonlinear, moving back and forth in his memory. Two recurring events surface when Caleb insists that he be allowed to leave: (1) a time when he had been accused of stealing from his company, and (2) his son's funeral. At least once a day, Caleb wants to leave to “take care of” the situation. He is encouraged to express his distress and unresolved grief to the staff, and over time these memories become less emotionally charged. Treatment includes exploring ways to engage Caleb in tasks associated with successful past roles. His family is included in this process and eventually they take over. Engaging Caleb in activities that once brought him a sense of identity and competence prove very successful. Caleb begins to laugh and talk with his family, his ADL improve, and his aggression is eliminated.

**CONCLUSION**

Throughout both Marian's and Caleb's occupational therapy intervention, my focus remains the promotion of both mental and physical health through engagement in occupation. This is the result of my use of a therapeutic reasoning process that incorporates occupation-related theories. The tenets of the theories help guide me as I work with my clients to identify goals that are meaningful and relevant to them. Helping clients and their families create routines that incorporate occupation allows them to feel engaged in meaningful life roles and provides them with a sense of control and satisfaction. Providing the family with an understanding of the importance of...
occupation gives them the knowledge to make decisions about long-term care that take into account their family member's optimal engagement in desired occupations. Lastly, because the therapeutic reasoning process can help direct theory, I have the structure and language to explain to my teammates the benefits of helping someone engage in meaningful occupation, thus creating a unique and valuable place for occupational therapy on the treatment team.

REFERENCES


March 23, 2009

Learning Level: Intermediate

Target Audience: Occupational therapists and occupational therapy assistants

Content Focus: Domain of Occupational Therapy, Areas of Occupation, Occupational Therapy Process, Evaluation and Intervention

1. Which of the following does not contribute to mental health issues for older adults?
   A. Fear of falling
   B. Getting older
   C. Medication overdose
   D. Serious physical illness, such as heart failure or cancer.

Exam continued on page CE-8
2. Level of education, as well as continuing education, are two indicators for successful aging. Which of the following is also a factor?
   A. Being able to remain in one’s own home
   B. Absence of serious illness
   C. Remaining actively engaged in productive activity
   D. Having financial security

3. The landmark Well Elderly Study indicates that occupational therapy intervention can help older adults avoid a decline in health and daily function. Which of the following key concepts in the study results support this assumption?
   A. The subjects in group two, who were provided with structured social activities, showed the same decline as the control group.
   B. Individual attention for subjects in the study group did not affect the end results.
   C. All subjects benefitted from being in the study, regardless of which group they were assigned to.
   D. Subjects in the social activity group showed the same benefits as those in the study group that received individual occupational therapy.

4. Which of the following is not considered a step in the therapeutic reasoning process?
   A. Creating the person’s story from the assessment results
   B. Generating clinical questions and collecting information
   C. Creating an intervention plan with the person
   D. Developing a standard form to be used with all clients

5. Step one of the therapeutic reasoning process is to choose a guiding practice theory and create which of the following?
   A. A description of the problem the person is presenting with
   B. A list of clinical questions that will form the basis for all future steps
   C. An evaluation to start with
   D. Ways to help the person determine what he or she wants out of the treatment process

6. Assessments are chosen by considering the clinical questions as well as the person’s age, cognitive capability, and developmental stage in life.
   A. True  B. False

7. Which of the following questions best determines occupational competence when using the therapeutic reasoning process with the Model of Human Occupation?
   A. What roles does Marian see herself as holding in society?
   B. Does Marian feel she has been able to meet her past role responsibilities and accomplish her goals?
   C. What is Marian’s daily routine?
   D. What sort of support will Marian need to remain at home?

8. After collecting data, the therapist organizes this information by answering the clinical questions created in step one. This step is meant to do what?
   A. Generate the treatment plan
   B. Gather information through formal or informal means
   C. Create a picture of the client’s situation
   D. Assess outcomes

9. All steps in the therapeutic reasoning process are completed individually and in the order in which they are presented.
   A. True          B. False

10. Which of the following is not one of the interrelated concepts in the Model of Human Occupation?
    A. The influence of the environment on occupation
    B. The development of identity through competence in occupations
    C. Cognitive levels that influence decisions about function
    D. Identification of the factors that motivate people to participate in occupations.

11. The idea of looking to past occupations to understand and interpret Caleb’s behavior is drawn from which theory about communicating with confused older adults?
    A. Validation Therapy
    B. The Model of Human Occupation
    C. Cognitive Behavioral Therapy
    D. The therapeutic reasoning process

12. Caleb is no longer able to manage his utensils during meals. Using retrogenesis to guide the therapeutic reasoning process, what clinical questions might the therapist ask to begin creating Caleb’s intervention?
    A. What cognitive and perceptual motor skills does Caleb have relative to managing toileting and dressing?
    B. What tasks related to ADL can Caleb complete using cueing and set up?
    C. What activities and occupations does Caleb engage in and enjoy, and what modifications can be made to allow participation?
    D. All of the above