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Infusing Occupation Into Practice
Valuing and Supporting the Psychosocial Foundation of Occupation

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ABSTRACT
The reaffirmation of occupation-based practice creates both opportunities and challenges. Taking time to ask clients about their lives, understanding daily occupational performance patterns, and designing individualized interventions relevant in the larger contexts of clients’ lives may be difficult to achieve in your practice setting. However, enabling individuals to choose and participate in a full range of meaningful occupations reaffirms occupational therapy’s commitment to the psychosocial foundation of occupation and is the key to successful and lasting occupation-based outcomes.

LEARNING OBJECTIVES
After reading this article, you should be able to:
1. Recognize psychosocial issues affecting engagement in contextual occupational performance.
2. Identify strategies for identifying and maintaining a psychosocial focus with clients.
3. Identify interpersonal competencies central to client-centered practice.
4. Identify strategies for developing an occupational profile as the first step of the evaluation process.

INTRODUCTION
People have rich and varied lives that are part and parcel of their experience of disability, injury, or illness, whether present from birth or occurring later in life. These events and the feelings associated with them helped to form their lives before they became clients of occupational therapy. Enabling people to choose and engage in a range of meaningful daily occupations reaffirms occupational therapy’s commitment to the psychosocial foundation of occupation, a central belief in the process of achieving successful, meaningful, and lasting functional outcomes.

Occupational therapists and assistants understand a person’s ability to perform daily activities from the perspective of the active interrelationship of that person’s unique abilities within the multidimensional contexts of their temporal, physical, and social environments. Interruption in the ability to take part in necessary and valued daily occupations elicits emotional and psychological responses central to how the person responds and eventually adapts to the interruption of a daily routine.

Occupations have two dimensions: the observable performance dimension relating to “doing” and the unobservable dimension of personal meaning, only learned by asking clients about their occupations and taking the time to fully understand their point of view. In talking to clients about their lives, we come to an understanding of how psychosocial issues affect their daily routines (Christiansen & Baum, 1997). Understanding both the observable and unobservable dimensions is central to the process of evaluating the need for and planning occupation-based interventions and outcomes. The psychosocial foundation of occupation then becomes very clear—it is not a special technique added to practice, but an integrated, everyday occurrence. Yet asking clients what they need or want to do in order to plan meaningful and relevant occupation-based interventions is too often constrained by time limitations, workplace priorities, and reimbursement systems.

As occupational therapists and assistants, we may have different goals, beliefs, and values from our clients. It may feel uncomfortable to encourage clients to choose their own goals, especially when cognitive, developmental, physical, or psychological impairments are present. Clients’ desired occupations may be seen as “unrealistic” within a particular practice setting. Lastly, hesitation in gathering qualitative information about a client’s perspective may be due to the practitioner not feeling skilled or comfortable with methods to elicit a client’s concerns, feelings, and occupational history. Lack of support from the work environment or insufficient time to design occupation-based interventions also interferes with this process.

THE PSYCHOSOCIAL FOUNDATION OF OCCUPATION
The psychosocial dimensions of human performance are readily acknowledged in the literature as fundamental to all aspects of occupational therapy, with every client population and in all practice settings. Occupational therapists and assistants understand the ability “to do” from a dynamic and interactive relationship between the client and performance abilities, the demands of the activity, and the physical and social contexts within which the activity is performed (Dunn, Brown, & McGuigan, 1994; Fidler, 1997; Youngstrom, 2002).

Overarching all occupational therapy practice is the primary perspective that a person’s fundamental occupational performance is sustained by the interrelationship of daily living patterns, including values, interests, and hopes. These are
preexisting to whatever need brought the client to occupational therapy. Taking the time to understand how the past and present converge—what is currently important and meaningful to the client as well as past roles, experiences, strengths, and patterns of coping—all shed light on current issues and problems. All performance is seen through this psychological—emotional—social screen (American Occupational Therapy Association [AOTA], 2002; Bonder, 1997).

The second perspective is the overlay of psychological and emotional responses that occur as a result of injury, illness, or disability. These personal consequences are unique to the client and may include anger, denial, fear, hopelessness, refusal to participate, lack of motivation, loneliness, anxiety, grief, feelings of loss, and other emotions. These issues transcend a specific diagnosis or practice setting and are a primary influence on recovery and the ability to resume meaningful occupational routines. Although the psychological reactions may not be the primary reason for referral, the relationship between these elements and the primary diagnosis must be understood and addressed if client-centered, meaningful, occupation-based outcomes are to be developed and accomplished (Fidler, 1997). Thus, if engagement in occupation is to occur, both the subjective and objective aspects of performance must be addressed.

The need to comprehensively address psychosocial issues goes beyond the concept of “screening,” which implies that psychosocial issues may not be pertinent to a client or can be ruled out and not considered. A constant appreciation of the impact of psychosocial issues on occupational performance is the foundation on which all occupational therapy evaluation, intervention, and outcomes are based. The efficacy of occupational therapy intervention is measured by its considered inclusion of these principles and beliefs, regardless of the nature or acuteness of a disability (Yerxa, 1967).

There is a difference between the psychosocial foundation of occupational therapy and the specialty practice of mental health:

Like other areas of specialization, mental health practice is grounded in the psychosocial core concepts of the profession, but like other specialties in occupational therapy it reaches beyond this core to develop a specialized knowledge and expertise that is applicable to a particular population or disability. (Fidler, 1997, p. 869)

Many occupational therapy practitioners lose interest when they hear the word psychosocial, assuming that it refers to clients with mental illness. Some practitioners believe that they already address psychosocial issues. Others say it is not the focus of intervention, is not reimbursable, or is impractical in their practice setting. Occupational therapy students may say that in their physical or pediatric fieldwork settings their clinical instructors did not mentor them in the area of psychosocial issues. Yet if the psychosocial aspects of a client’s life and response to disability, illness, or injury are not addressed, the therapist risks being relegated to the level of a technician who looks only at the obvious, quantifiable problem and not at the context within which the client is experiencing functional difficulties in occupational performance.

Asking clients about their goals is an established part of any occupational therapy evaluation and is required by accrediting and licensing agencies. However, asking clients who may not understand what occupational therapy is to identify a goal may lead to statements such as “I want to go home,” “I want to take care of myself,” or “I want to feel better,” hardly enough information to identify meaningful occupations, daily routines and interests, and desired goals. Most documentation evaluation forms include a section for psychosocial issues. However, responses are often limited to comments such as “pleasant and cooperative,” “has a supportive family,” or “resistive.” They do not address the richness of the person’s life, what he or she is feeling, or the details of what he or she wants to do. Practitioners may not ask about these issues because they may feel uncomfortable with the client’s response or they don’t know what to say when a client says something such as “I want to die” or “I don’t even know why you are asking me these questions. I just want to go back to how I was before.” However, these statements provide a beginning insight into the client’s subjective experience of the situation and serve as a taking off point for the therapist to gather more qualitative information about how the client’s psychosocial state is affecting occupational performance.

### Psychosocial Aspects of Occupation and Purposeful Activity

The Occupational Therapy Practice Framework: Domain and Process (AOTA, 2002) (Framework) defines occupation as “activities of everyday life, named, organized, and given value and meaning by individuals and a culture. Occupation is everything people do to occupy themselves, including looking after themselves ... enjoying life ... and contributing to the social and economic fabric of their communities (Law, Polatajko, Baptiste, & Townsend, 1997, p. 32)” (p. 610).

The Framework provides further clarification in describing the purpose of occupation-based activities as allowing clients to engage in occupations that match their goals and are part of their own life contexts. It defines purposeful activity as allowing the client to engage in goal-directed behaviors or activities within a therapeutically designed context that leads to returning to necessary and valued occupations. But goal-directed, purposeful activity is not sufficient in itself. Occupation must be both purposeful with regard to incorporating a person’s unique reason for engaging in a particular activity, and meaningful with regard to the personal significance of the activity.

**Case Example:** After a brief inpatient hospitalization for a stroke resulting in left hemiplegia, a 78-year-old man is
seen in outpatient occupational therapy. His illness left him with moderate impairment of gait and left hand use. He is having difficulty doing things for himself, requiring help from his elderly wife and other family members. He is very upset and sad, having always been an independent person. He was an auto-body mechanic prior to retirement and always enjoyed using his hands to build furniture for his home and toys for children as well as to fix things around the house. He had continued these pursuits on a daily basis until the stroke.

After the initial evaluation, which the man reports went well, the occupational therapist suggests that he come to a small group session two times per week. The man attends the group one time and comes home with a small Popsicle craft package. When his family asks how therapy went, he angrily states he is not going back because it is a waste of time and he feels offended by the craft packet. His family asks why he was given the craft, but he has no idea. His family urges him to return to therapy and give it another try, but they are unable to convince him to go.

This true scenario represents a missed opportunity. A client who, prior to his illness enjoyed and valued occupations that involved the skilled use of his hands, was provided with an activity that held no meaning for him. In fact, it held a negative meaning. To this client, the activity was not motivating, was personally demeaning, and bluntly reminded him of what he had been able to do but could no longer accomplish. Even though the craft provided addressed fine motor goals, was a “purposeful activity,” and may have been chosen because he liked to work with his hands, collaborating with the client to choose an occupation-based intervention that considered his current abilities as well as past skills and interests would have been more successful. Only by taking time to talk to this client and completing an occupational profile would the therapist have been able to facilitate his engagement and move him toward regaining abilities to participate in his valued occupations.

Occupations take on a subjective importance that purposeful activity may not. The experience of engaging in occupation to support participation in context is the core of our professional domain and helps us recognize when interventions are focusing on task performance but are still connected to participation in meaningful roles and routines (Youngstrom, 2002). This seems like a simple concept. In the real-world setting of everyday practice, it can be quite difficult to accomplish. Addressing psychosocial issues and placing importance on the meaning of occupation influences how we practice. Understanding a client’s perspective can mean the difference between success and failure in therapy (Christiansen & Baum, 1997).

**CLIENT-CENTERED PRACTICE**

Clients are sometimes described as unmotivated, uncooperative, not having rehabilitation potential, or resistive. When viewed within the context of the client’s situation, these may be inaccurate assumptions. We may be talking about the wrong goals, presenting irrelevant activities, or simply presenting occupational interventions in a way that is beyond the capacity of the client at that moment. Occupational therapists and assistants believe that the client is central to the therapy process, but putting these concepts into everyday practice is challenging. We must demonstrate client-centered behaviors actually recognized by the client. In order to support a client’s ability to participate in desired occupations, a climate of respect and interest must be present from the first meeting, recognizing him or her as a person as well as a client. Occupational therapists and assistants can create a supportive and accepting environment, using their expertise to support successful occupational performance. This is the core of the client-centered foundation of occupation.

Clients come from different backgrounds and life experiences. How they make choices about their daily occupation is unique to them and their personal situations. For example, Sarah, an 80-year-old woman with Parkinson’s disease, lives in an assisted living facility, and is in a wheelchair. She is told in rehabilitation sessions that she needs to walk and dress herself. She asks her case manager if she has to because she would rather focus on going to the theater and buying gifts for her grandchildren. Sarah says walking and dressing take up too much time and energy, and having someone help her is fine. Shifting the power of decision to Sarah, listening to how she wants to spend her time, and appreciating her hopes at this stage of her life creates a collaborative partnership, enabling her to work with the occupational therapy practitioner on generating and implementing strategies to meet her goals. Occupational therapy practitioners need to talk to clients, spending enough time to learn about their experiences; asking questions about what they do; identifying personal characteristics, skills, and environmental contexts; and understanding how they interact to achieve successful occupational performance.

Lyons, Orozovic, Davis, and Newman (2002) in a qualitative study examined the occupational functioning of adults with life-threatening illness in a day hospice program. Areas of concern for the people participating in the study included maintaining valued occupations and preserving physical and mental functioning in the midst of severe illness. Collaborative occupational involvement for these adults resulted in the preservation of a sense of self-worth and well-being by engaging in social relationships, exploring new activities, and learning new skills—prolonging their ability to engage in the “doing of their life’s occupations” (p. 294).

Rebeiro’s (2000) qualitative study of the experience of two clients with occupational therapy mental health services highlights the challenge of client-centered practice in the current health care setting. Although these clients viewed their occupational therapy as less than client centered, they affirmed occupation as important for their own lives.
The participants stated that the prescription of “activity,” a lack of choice, and a focus upon the illness as opposed to the individual served to diminish any collaborative partnership with the client and eliminate the client from any decision-making process. This distancing from the client, in their opinion, served to greatly diminish any therapeutic value of occupation. The participants recommended a greater focus upon occupational choice, consideration of the individual within the client, providing accepting, supportive environments, and using professional expertise on occupation to guide the client towards participation in meaningful occupation. (p. 7)

Current health care systems often do not encourage the art of practice. There are practical issues to be dealt with on a daily basis—team philosophies and expectations, staffing constraints, charting and productivity requirements, and limits on the number of visits or the scope of services provided, all of which are challenges to providing contextual occupational therapy. However, the nature of the client’s occupation must be understood before we move to any meaningful intervention. The absence of a client-centered evaluation approach prematurely moves the therapist to the second tier of the evaluation process, with a focus solely on an analysis of client factors causing performance problems. Using client-based evaluations to identify priorities and then identifying the personal factors that support or limit performance will save resources and time spent on long assessments that gather much information but are not important for the client, and limit time for intervention. This method focuses the intervention plan on occupational areas meaningful to the client, actively engaging him or her in the therapeutic process from the beginning.

Some practitioners believe that client-centered evaluations rely too much on insight and verbal responses, and that the ability of some clients to provide a description of desired occupations is limited due to their developmental stage, communication deficits, or the nature of the diagnosis itself. We must be careful about making assumptions about what clients want. Assumptions cannot be made based on what we think of the client’s level of insight, cognition, or communication. Even when clients have difficulties in these areas they still have occupations they do and goals they want to achieve. It is our responsibility to develop skills in eliciting this information. As occupational therapists and assistants, we are lucky to have an asset unique to us—our knowledge and skill in attending to both the verbal and nonverbal expression of what constitutes meaningful, occupational performance (Peloquin, 1995). When the client is unable to provide input, family members or other significant people in their lives may then become a co-client in occupational therapy services. Collaborating with them allows the client to be represented.

STRATEGIES TO ENHANCE PSYCHOSOCIAL FOCUS

Psychosocial focus is fundamental to our profession, but how do we objectively go about implementing this in our daily practice? The first interaction with the client plays an enormous role in establishing the nature of the therapeutic relationship. Baum (1980) wrote, “we are nothing more than a bystander in the life of a patient until a relationship is formed” (p. 514). Despite occupational therapy’s long-standing tradition of collaboration, much of our education and training are focused on formal procedures for assessing physical or developmental characteristics. Less time is spent on teaching strategies for developing relationships, engaging clients, and identifying desired occupations. Although these areas are usually covered in a communication class, they are often seen as part of the mental health course and may not be fully integrated into other core occupational therapy content. They may be addressed in a more informal and less structured way. This may imply that the psychosocial aspects of occupational functioning are not as important as identifying specific physical or developmental performance deficits.

Students doing psychosocial fieldwork placements sometimes say they really liked mental health but want to work first in a physical rehabilitation setting to “cement” their skills because they are fearful of losing technical knowledge and skills. Rarely do we hear the opposite—that students want to continue to develop psychosocial competencies in the therapeutic use of self, empathy, and the interpersonal skills necessary for genuine collaboration with clients.

Involving Clients in the Process

Involving clients more fully in the evaluation and intervention process elicits motivation to engage and supports developing competencies in valued and necessary occupations. However, most clients initially do not know what occupational therapy is. Our domain of practice is complex and not well understood. Clients do not say, “I lost meaning in my occupation” or “I lost my role as homemaker.” For some clients it is easy to identify concerns—we just need to ask and then listen. For others, recognizing occupational problems is difficult and is a challenge to themselves and to our skills in understanding what they are trying to convey. If the engagement process is done well, the client is motivated to collaborate in therapy. If done poorly or taken for granted, successful outcomes are limited. The nature of occupational therapy must be explained to the client in terms that are personally meaningful and understandable.

The engagement process is purposeful, and although the approach may seem casual it is anything but. Client-centered practice is not just getting to know a person but relies on developing a trusting and empathic relationship, being emotionally available, keeping a client-centered focus, and using interpersonal skills to engage the active acceptance of the client. Collaboration occurs when the client understands why occupational therapy is involved and what he or she can expect to achieve, and when the occupational therapy practitioner completely understands the client’s situation (Christiansen & Baum, 1997).
Scenario #1: A mother arrives for an initial occupational therapy evaluation of her 4-year-old son. After greeting the therapist somewhat coldly, the mother says very loudly, "I don’t even know why we’re here. He doesn’t have any problems." The therapist thinks this a noncompliant parent and quickly replies that if the child does not need to be evaluated, the appointment can be cancelled. The mother agrees, and leaves. This conversation occurs within the first 5 minutes of the mother’s arrival, leaving the therapist with 90 nonbillable minutes during which the evaluation was supposed to take place. Two days later, the referring physician calls the therapist to see why the child was not seen because he does have significant developmental delays.

Scenario #2: A mother arrives for an initial occupational therapy evaluation of her 4-year-old son. After greeting the therapist somewhat coldly, the mother says very loudly, "I don’t even know why we’re here. He doesn’t have any problems." The therapist invites them into the treatment room.

The therapist asks them to sit down and makes small talk for a few minutes. The mother visibly begins to relax. The therapist notices that he is playing in an immature way for his age and appears to have clumsy fine and gross motor skills. He is not making eye contact with his mother or the therapist, nor does he reference either adult or respond to any questions. The therapist asks for the mother’s patience as she quickly scans the physician’s report, as well as reassures the mother that it is her choice as to whether the child has therapy or not. The therapist is there to assist her with the decision, but not to make it for her.

The mother tells the therapist that she and her husband had just received the physician’s report a week earlier and she is in the midst of scheduling and going to speech and physical therapy appointments. The mother begins to cry, saying she wants to do everything she can for her son but feels overwhelmed. The therapist reassures her and asks if she would like her to go ahead with the evaluation. The mother responds positively and the evaluation proceeds quite smoothly, with the mother supplying many details about what her son likes to do, what he has difficulty with, as well as her goals for him. At the end of the session the mother says she thinks therapy would be a good idea for her son and she is glad she came. The evaluation has taken place within the scheduled time, with the therapist feeling that she has a good idea of the qualitative and quantitative aspects of the child’s performance abilities within the context of his family situation.

Developing Psychosocial Competencies

Occupational therapy practitioners need to develop and maintain psychosocial competencies in order to be able to use client-based evaluation and intervention as opportunities to communicate caring and commitment, a desire to understand the context of clients’ lives, and sharing skills and expertise in the accomplishment of meaningful occupations.

This is more than a desire to help others, a skilled application of scientific knowledge, or being a sympathetic listener (Mosey, 1981). A client-centered approach means having a genuine interest in the client, participating in his or her experiences and sharing frustrations and successes. The collaborative process between practitioner and client rests on competency in understanding the complex psychosocial dimensions of occupational performance. Understanding the interpersonal dynamic of a therapeutic relationship is then a fundamental professional skill critical to the delivery of occupational therapy in all contexts (AOTA, 2002). Technical skills only work within the context of a relationship and forming any relationship requires both caring and interpersonal skills. The therapeutic use of self is acknowledged for the first time in the new Framework as a specific intervention and is described as the planned use of the practitioner’s personality, insights, perceptions, and judgments as part of the therapeutic process (AOTA, 2002, adapted from Punwar & Peloquin, 2000). The importance of this skill extends beyond the relationship with the client to collaboration with team members, families, and significant others. Although it is not unique to occupational therapy, it is key to enhancing the evaluation and intervention process.

Therapeutic Use of Self

Mosey (1981) describes the art of occupational therapy practice as including the ability to establish rapport, to empathize, and to facilitate choices about occupation and human potential; thus, the process of making connections and finding meaning. Otherwise, occupational therapy is only the application of knowledge in a sterile vacuum (Mosey, 1981; Peloquin, 1998). Occupational therapy practitioners must develop self-awareness, engaging in the often-uncomfortable process of learning about and changing themselves, as well as clarifying how their personal attitudes, values, expectations, and biases may differ from others (Mosey, 1981). It is not just learning a set of skills, but a personal process of understanding how to use one’s self to effectively help others. Reflective thinking involves a consistent and ongoing checking-in process with your perceptions. In order to think reflectively about your interactions with clients, ask yourself: What do I see happening? Do I understand this perspective? Is my view the same? How are my values different or the same? (Gitlin, Corcoran, & Leinmiller-Eckhardt, 1995).

Interpersonal skills are used as a tool to help communicate caring and collaboration, as well as to elicit information on how clients spend their time, what they are good at, what is difficult for them, typical coping mechanisms, and what they hope to accomplish. Asking clients questions to help understand their lives might include: What is a typical day like for you? How is it now versus before? What are you worried about? How do you manage your day? How do you feel about the future? It is then important to confirm that you understand what the client means, asking questions

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such as: Is this how you see it? So you are saying that when you feel that way, you respond this way? Am I understanding you correctly? Does this upset you? (Gitlin, Corcoran, & Leinmiller-Eckhardt, 1995).

Skills in interviewing, such as active listening, probing, reflecting, and paraphrasing to clarify issues and goals, asking open-ended questions, summarizing, and using a sense of humor appropriate to the moment are critical in enabling clients to describe performance issues they are dealing with. Understanding the benefits of self-disclosure and when and how to set limits or boundaries is also important. Denying the client’s or your own feelings or dismissing concerns as not being appropriate to your setting limits collaboration and gets in the way of successful outcomes.

When clients see us as being genuine, respectful, taking the time to listen and understand their situation, and sharing feelings and concerns they are more likely to trust us and feel confident in talking about their personal lives. If trust is not present, the content of interactions may be general and superficial, providing little helpful information about what is important to the client. Empathy assumes a unique character in occupational therapy, a practice in which therapists and assistants bring the trappings of occupation, objects, tools, and activities to the personal encounter with the client (Peloquin, 1995).

Developing a profile of a client’s daily occupations and patterns of doing requires the client to reveal the personal meaning that makes up his or her lifestyle. Eliciting and understanding the wealth of information in a client’s life story allows the occupational therapist to select activities related to the client’s occupational interests and needs and to design therapeutic experiences relevant within the larger context of his or her life. Examining all elements interfering with and supporting occupational performance ensures more sustained, enduring, and relevant outcomes.

Developing an individual lifestyle profile then becomes a critical first step in helping to define intervention goals as well as an outcome focus for practice (Fidler, 1996; Hasselkus & Rosa, 1998; McLaughlin-Gray, 1998). Approaches to completing an occupational profile will vary depending on the client and the practice setting. It may be completed in one session or initiated and developed over time, and obtained through a variety of methods such as structured and unstructured interviews, narratives, or life histories. An informal interview may be useful for initial rapport building, setting a relaxed tone, and communicating a willingness to listen. Client-centered evaluation depends on self-report and accepts it as the most relevant source of information. The more open ended the evaluation, the richer the opportunity to hear the client’s genuine experiences of occupation and disability (Pollock & McColl, 1998).

Insight also is gained through spontaneous conversations with clients that arise during interventions. As clients become more comfortable and trust is established, they reveal more detailed and meaningful information about their occupational selves. This information is used in a continuous process of reevaluating and determining effectiveness of interventions and progress toward targeted outcomes.

The next step in the evaluation process involves the occupational therapist actively observing the client’s performance of the occupations identified as a priority. The dynamic nature of performance is a relationship between the client; the temporal, social, and environmental contexts; and the activity demands. The client’s internal process of self-assessment often must be inferred from observation or self-report. This is why it is so important to see the client doing and know the client’s occupational nature fully in order to understand how these variables influence performance. Clinical reasoning drives the method of observation, from an in-depth assessment of selected aspects of performance to a determination that trained observation of actual performance can provide enough information on the extent or reason for the performance problem. The therapist then interprets the data to identify what supports or limits performance, which serves as the basis for the intervention plan (AOTA, 2002).

CONCLUSION
When occupation is viewed within the contexts of the actual demands of a client’s daily schedule, the focus and trajectory of therapy is defined and delineated by personal experience of purpose and meaning and is not obscured by the practitioner’s own priorities for intervention (Fisher, 1998). Addressing the psychosocial foundations of occupation and client-centered practice leads to engagement in meaningful and relevant occupations and guides the occupational therapy practitioner, facilitating occupation-based practice. Developing psychosocial competencies helps occupational therapy practitioners get from where they are in current practice to where they would like to be, practicing in a more meaningful and contextual model.

Mastering the art of practice requires us to demonstrate understanding and skill in creating a climate of caring (Yerxa, 1980). It demands accommodating limitations inherent in our practice environments while addressing the often-devastating psychosocial consequences limiting full participation in meaningful daily occupations. Viewing each person as a whole, establishing relationships, empathizing with the experience of illness and injury, and understanding personal feelings and values that contribute to a meaningful life help to create an environment in which care can flourish (Mosey, 1981; Peloquin, 1998).

REFERENCES
How To Apply for Continuing Education Credit:

1. After reading the article Infusing Occupation Into Practice: Valuing and Supporting the Psychosocial Foundation of Occupation, answer the questions to the final exam found on p. CE-8 by darkening the appropriate boxes in Section B of the Registration and Answer Card, which is bound into this issue of OT Practice following the test page. Each question has only one answer.

2. Complete Sections A through D of the Registration and Answer Card. If the Answer Card is missing from your issue, you may obtain a form online at www.aota.org under Continuing Ed, CE article.

3. There is a nonrefundable processing fee to score the exam, and continuing education credit will only be issued for a passing score of at least 75%.

4. Send the card with a check for the appropriate amount (payable to AOTA) or credit card information to: American Occupational Therapy Association (CE) PO Box 64950 Baltimore, MD 21264-4960

5. Registration and Answer Cards for Infusing Occupation Into Practice: Valuing and Supporting the Psychosocial Foundation of Occupation must be received on or before June 30, 2005.

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Final Exam

Infusing Occupation Into Practice: Valuing and Supporting the Psychosocial Foundation of Occupation • June 2, 2003

Learning Level: Entry level
Target Audience: OT and OTA
Content Focus: Category 1: Domain of OT: Client Factors
Category 2: Occupational Therapy Process: Evaluation and Intervention

The Registration and Answer Card can be found bound into this issue of OT Practice following the test page, or on our Web site at www.aota.org under Continuing Ed.

1. Occupations in a clients' lives are accomplished:
   A. In context of that person’s experience
   B. Temporally, physically, and socially
   C. Out of context
   D. Both A and B

2. The psychosocial issues in occupational therapy are:
   A. Primarily used in mental health practice
   B. A highly specialized technique used with certain client populations
   C. Integrated into all practice
   D. Too time-consuming and labor intensive to consider in many practice settings

3. When clients experience injury, illness, or disability:
   A. They have very little emotional or psychological response to their situation
   B. They probably will experience a number of negative emotional responses
   C. Their emotional responses are best left to a psychiatrist or psychologist to deal with
   D. Have little impact on occupational therapy for their primary diagnosis

4. Psychosocial issues with any client:
   A. Can sometimes be ruled out as a focus of intervention
   B. Are present for all people receiving occupational therapy services
   C. Can be addressed by an initial screening evaluation
   D. Should be considered only secondary to physical diagnosis

5. An underrecognized element for client refusal to participate in therapy is:
   A. Fear of an unknown situation
   B. Disinterest in getting better
   C. Having an anger-management problem
   D. Not taking responsibility for his or her situation

6. In client-centered practice, when a client is asked what his or her goals are:
   A. The therapist should reasonably expect a focused and relevant answer
   B. The therapist should ensure that the client is cognitively intact
   C. The therapist needs to provide the client with the opportunity to talk about previous daily routines
   D. The response must come only from the client

7. A well-analyzed activity presented to a client:
   A. Is usually acceptable to him or her
   B. Can be an activity that addresses client goals but may not be accepted by the client because it is not personally meaningful
   C. Is sometimes refused, meaning the client is resistive to therapy
   D. Has little to do with the personal values of the client

8. A screening process is adequate to rule out the psychosocial issues of a client:
   A. True
   B. False

9. Client-centered practice involves:
   A. Building a good rapport with a client so the therapist can more accurately direct the intervention
   B. Knowing a client well enough so the therapist can set reasonable and attainable goals
   C. Spending extended time with the client initially so the therapist can recognize the themes of the client’s life
   D. Gaining only initial information about the client’s contextual daily occupations

10. In a qualitative study of adults with mental illness, they:
    A. Did not view occupational experiences as important in their lives
    B. Viewed their participation in occupational therapy as client centered
    C. Wanted to be collaborative participants with the therapist regarding their intervention goals
    D. Did not appreciate the expertise of the occupational therapist in the evaluation process

11. Barriers to engaging in the art of practice include:
    A. Focusing on qualitative client information
    B. Focusing on the second tier of the evaluation first
    C. Having to use a variety of interview techniques with clients
    D. Deciding to use only highly focused assessment

12. Interpersonal skills that can be used in interviewing clients:
    A. Can include active listening, asking open-ended questions, and using a sense of humor
    B. Should not take into account the therapist’s or client’s affective response to the situation
    C. Involve never setting a boundary on client’s responses
    D. Involve too much time on the part of the therapist to be successfully used in client intervention.