Chapter 1

Introduction

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Occupational therapists are concerned with the anatomical and physiological substrate of human behavior, the in-depth analysis of human occupation throughout the lifespan, and the effects of disabling conditions on functional behavior. Whether they are engaged in institution- or community-based practice, occupational therapists must analyze, synthesize, and relate complex arrays of observational and evaluative data and design intervention strategies that facilitate their clients' meaningful participation in the tasks of life. Experienced clinicians have learned that attention to the client's personal context facilitates clinical problem solving and the development of relevant and effective intervention strategies.

This book is based on an ecological approach to the practice of occupational therapy, in which the therapist's knowledge of theory and clinical conditions is interwoven with the client's personal experience and aspirations. The evaluation, interventions, and related outcomes of treatment are viewed as interacting determinants of one another. Successful application of theory to practice requires that occupational therapists use abstract skills, such as critical thinking, clinical reasoning, and clinical problem solving.

The manner in which practitioners engage in the clinical reasoning process has been described and operationalized in the literature (Mattingly & Fleming, 1994; Schell, 2009). The simultaneous employment of procedural, conditional, narrative, and ethical aspects of the clinical reasoning process requires the therapist to interweave theoretical knowledge of disabling conditions with the individual client's aspirations and personal experience, in order to create a relevant and viable treatment program (Mattingly & Fleming, 1994; Schell, 1998).

Critical thinking, clinical reasoning, and clinical problem solving are complex processes that are central to the practice of occupational therapy but not readily visible to the learner. The hallmark of the progression from novice to expert is an increase in the efficiency of the clinical reasoning process—the speed, flexibility, and accuracy with which contextual data, clinical problem definition, evaluation,

and the design of the treatment plan are integrated and implemented. The keys to expert performance are experience, organization of knowledge, efficiency in gathering and organizing data, and reflectivity (Johnson, 1988; Mattingly & Fleming, 1994). The primary task as one progresses toward expertise is not only to amass knowledge but also to develop increasingly more efficient strategies for organizing and manipulating that knowledge for problem solving (Bruer, 1993; Lave & Wenger, 1991).

The traditional method of transgenerational transmission of professional information has been based on an apprenticeship model, in which the expert clinician "makes thinking visible" (Collins, Brown, & Holum, 1991, p. 6). The components of apprenticeship—modeling, scaffolding, fading, and coaching—represent a progression from demonstrated problem solving, to guided problem solving, and then to independent problem solving.

First, the expert *models* the target process, often showing the novice what to do. Then, the expert provides a *scaffold*, or support, as the novice carries out a task. The level of support can vary from carrying out a task with the novice to giving occasional hints as to what to do next. *Fading* refers to the gradual removal of support as the novice assumes more and more responsibility. *Coaching* is an ongoing effort by the expert to oversee the novice's learning by choosing and structuring tasks, providing hints, diagnosing problems, offering encouragement, and giving feedback (Collins et al., 1991).

Metacognitive strategies, such as conceptual frameworks, help to reify expert thought processes and provide a tangible model of expert thinking for the novice (Bruer, 1993; West, Farmer, & Wolff, 1991). Reification of thought processes facilitates teacher and student interaction and can help the student become more cognizant of efficient methods for ordering and using information for clinical reasoning and independent problem solving (Lave & Wenger, 1991; Resnick, 1987; West et al., 1991).

The trend away from institutional toward community-based services and administrative downsizing in all arenas, including health care, leaves novice occupational therapists and experienced therapists who have transitioned to new practice areas with diminished access to expert on-site supervisors. As a result, there are fewer opportunities for the interactions described above, which are inherent in a progressive, interactive apprenticeship.

Purpose and Format

Although the written word cannot replace the interactive relationship between a novice and an expert practitioner, it is hoped that this book will provide the reader with the opportunity to see how some expert occupational therapists think. Each chapter is divided into five sections:

1. Synopsis of Clinical Condition
   - Prevalence and etiology

- Common characteristics and symptoms
- Target areas for intervention

2. Contextual Considerations
   - Clinical
   - Family
   - Practice setting
   - Sociopolitical
   - Lifestyle/lifespan
3. Clinical Decision-Making Process
   - Defining focus for intervention
   - Establishing goals for intervention
   - Designing theory-based intervention
   - Evaluating progress
   - Determining change in or termination of treatment
4. Case Study
   - Description
   - Long- and short-term goals
   - Therapist goals and strategies
   - Activity
   - Treatment objectives
5. Resources
   - Internet resources
   - Print resources

The structure of the book is consistent with the multimodal nature of the clinical reasoning process (Mattingly & Fleming, 1994). The synopsis of the clinical condition reflects the procedural aspects of clinical reasoning, and the contextual considerations make up the narrative or conditional aspects. The contributing authors identify the theories and/or frames of reference that inform their decision-making processes. They also indicate what frames of reference or theoretical models may be employed, either alone or in combination, depending on the clinical, family, practice setting, and lifestyle/lifespan context. In the Clinical Decision-Making Process section, the experts make their thinking visible (Collins et al., 1991) and model how they relate theory to practice. Finally, just as the master craftsperson introduces an apprentice to the rubrics of a craft by providing an example of a completed product, the experts provide a reification of their thought processes by providing a case study that includes an assessment and interpretation of contextual data, an action plan, and expected outcomes.

The book encourages readers to structure their thinking and become more efficient—more expert—in data gathering and analysis and in designing intervention that is grounded in theory and relevant to the context of the client.

Structured Reflectivity: The Relationship of Research to Practice

As noted earlier, reflectivity is an important component of expert practice. Evidence-based practice, outcomes measurement, and research are the functional manifestations of reflectivity and are necessary for the vitality of the occupational therapy profession (Holm, 2000; Laver-Fawcett, 2007). Reflectivity requires both the critical analysis of existing literature to inform practice decisions and the structured examination of the outcomes of treatment methodologies to assess their efficacy. Both practices simultaneously edify the individual clinician and the profession as a whole by evaluating and expanding the compendium of literature that informs and supports practice.

The *Occupational Therapy Practice Framework* (American Occupational Therapy Association [AOTA], 2008) identified occupation as both a means and an end, as well as the hallmark of occupational therapy. The *Framework* further defines the domains of concern for occupational therapy (areas of occupation, client factors, performance skills, performance patterns, context and environment, and activity demands) and helps define the unique outcomes of occupational therapy treatment to individual and institutional consumers.

Specification of the expected outcomes of occupational therapy intervention (occupational performance, adaptation, health and wellness, participation, prevention, quality of life, self-advocacy, and occupational justice) helps clarify the choice of measurement tools that will provide an accurate means of collecting and reporting data regarding the efficiency and efficacy of occupational therapy intervention.

Health policy–making bodies have articulated guidelines for acceptable methods of data collection and reporting that provide documentation with a patient-centered orientation. In other words, the focus is on reporting a more holistic picture of health that is footed in the context of the patient's/client's ability to function in daily life (AOTA, 2007; World Health Organization, 2010). Provision of clear outcome measures allows policy makers to make decisions regarding the inclusion and reimbursement of services.

In daily practice, therapists are required to make decisions regarding the type and duration of therapy and to make predictions regarding outcomes. The constituencies who pay for services will require more than intuition and experience as rationales for services. The primary challenge for occupational therapy practitioners is to create assessment processes that provide a comprehensive picture of the person–environment interaction and how that impacts the person's occupational performance.

Concepts such as occupational performance, role balance, and quality of life are difficult to quantify. Qualitative measures, which often incorporate observations and interviews, provide a method for systematically examining occupational performance. Both qualitative and quantitative assessment tools must be critically evaluated for reliability, validity, trustworthiness, and clinical utility.

In all arenas, the call for accountability and proof of efficacy of service reinforces the fact that institutional viability will depend on the reliability, validity, and clinical utility of assessment processes. The literature is replete with resources that provide comprehensive critiques regarding the reliability, validity, and clinical utility of a vast array of assessment tools (Law, Baum, & Dunn, 2005; McDowell, 2006). It is important to remember that there is no one perfect indicator of anything—what is important is "settling upon a consistent and intelligent method of assessing your output results, and then tracking your trajectory with rigor . . . what matters is that you systematically assemble evidence—qualitative or quantitative—to track your progress" (Collins, 2005, p. 8).

Clinicians who systematically cultivate their clinical curiosity by asking questions regarding the variables that affect and are affected by treatment are more likely to develop an evidence-based practice (Holm, 2000). The availability of electronic databases (e.g., MEDLINE, CINAHL, Cochrane Database of Systematic Reviews, ACP Journal Club, Evidence-Based Medicine Reviews, ERIC, PsychLit, OT Search) facilitates the search for evidence regarding the relationships among variables, such as populations, frequency, and duration of intervention and treatment outcomes. This curiosity, in tandem with clinical expertise, contributes to the development and maintenance of expert practice.

The evidence-based practitioner, through the systematic use of reliable and valid assessment tools, gathers and analyzes data that validate or question available evidence and contribute to the body of knowledge, documents client progress, and identifies the unique focus of occupational therapy: "supporting health and participation in life through engagement in occupation" (AOTA, 2008, p. 626).

The perspectives shared in this book are based on the clinical expertise of the contributors and on the current supporting literature. Since practice is contextual and evolutionary, it is expected that there will be myriad viable treatment methodologies applicable in each of the presented clinical situations.

The challenge to the practitioner is to evaluate these methods through literature review, systematically examine the outcomes of evidence-based practice, and contribute their findings to the knowledge base of the profession. With that in mind, it would be prudent for the reader to consider this book the beginning of a professional dialogue about treatment, rather than the last word.

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