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Motivation: An Occupational Therapists Guide for Motivating Young Male Clients with Spinal Cord Injuries

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Motivation: An Occupational Therapists Guide for Motivating Young Male Clients with
Spinal Cord Injuries

by

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Advisor: Anne M. Haskins, Ph.D., OTR/L

A Scholarly Project

Submitted to the Occupational Therapy Department

of the

University of North Dakota

In partial fulfillment of the requirements

for the degree of

Master's of Occupational Therapy

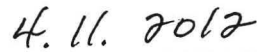
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This Scholarly Project Paper, submitted by Michael A. Nelson and Elizabeth M. Schleicher, in partial fulfillment of the requirement for the Degree of Master's of Occupational Therapy from the University of North Dakota, has been read by the Faculty Advisor under whom the work has been done and is hereby approved.

A handwritten signature in cursive script, reading "Anne M. Agis". The signature is written in black ink and is positioned above a horizontal line.

Faculty Advisor

A handwritten date in cursive script, reading "4.11.2012". The date is written in black ink and is positioned above a horizontal line.

Date

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Department: Occupational Therapy

Degree: Master's of Occupational Therapy

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Signature Michael Nelson Date 4-11-12

Signature Elizabeth Schweitzer Date 4-11-12

TABLE OF CONTENTS

ACKNOWLEDGEMENTS.....	vi
ABSTRACT.....	vii-vii
CHAPTERS	
Introduction.....	1-3
Review of Literature.....	4-32
Role of occupational therapy.....	6-7
Problem/Purpose Statement.....	7
Understanding Occupation.....	7-9
Motivation in occupational engagement.....	10
<i>Motivation and the Model of Human Occupation.....</i>	<i>10-14</i>
<i>The role of hope in motivation.....</i>	<i>14-16</i>
<i>Hope and peer-mentoring.....</i>	<i>16-17</i>
<i>Motivation and Occupational Adaptation.....</i>	<i>17-22</i>
Environmental considerations for occupation.....	22-25
Motivation Interventions and Assessments.....	25-26
The Therapeutic Relationship.....	26-28
Technology.....	28
Client Self-Efficacy, Hope, and Social Support.....	28-30
Formal Assessment.....	30-31
Summary.....	31-32

Methodology 33-36

Product..... 37-39

Summary..... 40-42

REFERENCES 43-48

APPENDICES

 Appendix A: Copyright Permissions

 Appendix B: Product

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Abstract

According to the Center for Disease Control and Prevention (2010), males account for approximately 80% of those who endure a spinal cord injury (SCI). Most newly diagnosed clients with spinal cord injuries are between the ages of 15-35 years (50%-70%) (CDC, 2010). Occupational therapists often work with clients who have sustained a SCI. It is in the best interest of the profession and our clients to address the psychosocial impact motivation can have on clients' recovery.

According to authors of research, a major problem to participation in treatment with clients who had a spinal cord injury was a lack of motivation (Chan et al., 2000; Craig et al., 2009; Kennedy, Evans, & Sandhu, 2009; Lohne & Severinsson, 2004). Due to clients' possible decrease in occupational participation following a SCI, motivation may be a barrier to recovery. There is limited research in occupational therapy regarding the use of motivation for clients with SCI as an intervention tool. In one study, Wahman, Biguet, and Levi (2006) indicated that motivation is a key factor in increasing client participation in activities. By engaging in activities clients are either improving or maintaining health and preventing secondary conditions.

The purpose of this project was to develop a guide to address motivation in young male clients following spinal cord injury (SCI). Historically, there has been little research that addressed motivation in relationship to engagement in occupations following SCI. For the purposes of this project, the authors examined the role motivation has in recovery of SCI for young male adults and developed an occupational therapy guide to address client motivation.

A comprehensive literature review was conducted to explore the physical and

psychological effects of clients who sustained a SCI. Furthermore, the authors conducted a theoretical review and explored literature that addressed the role of motivation in clients who sustained a SCI. Currently, there is limited research and programs available that specifically addresses motivation in clients engaging in SCI rehabilitation.

Therefore, an occupational therapy guide was developed for occupational therapists working with young male clients who sustained a SCI. This guide was developed using the theoretical concepts of the Model of Human Occupation (MOHO) and Occupational Adaptation (OA). The guide will direct clinicians to use motivational concepts as intervention strategies. This will give occupational therapists a resource to utilize when motivation is a barrier to client participation in meaningful occupations. By motivating a client with SCI, his participation in meaningful occupations increases. In return, young male clients with SCI have an improved quality of life. The development of this guide follows the occupational therapy process: assessment, intervention, and outcome measures.

Previous evidence from authors of research indicated the benefits of addressing motivation. In return, a clinician's guide for occupational therapists to address motivation in SCI recovery will increase clients' participation in activities to increase overall quality of life.

Chapter I

Introduction

Occupational engagement is essential to a client's well-being (Wilcock, 1993). Healthcare researchers have studied the effects of sustaining a spinal cord injury (SCI) within the occupational therapy scope of practice (Chan, Lee, & Lieh-Mak, 2000; Craig et al., 2009). According to the National Spinal Cord Injury Statistical Center (NSCISC, 2011), approximately 232,000 to 316,000 people in the United States are living with SCIs. An estimated 12,000 people each year sustain a SCI in the United States (NSCISC, 2011). Eighty percent of the population of SCIs is comprised of males (2011). Furthermore, most injuries occur in males, ages 16 to 30 years, indicating that young adult males account for the largest population who sustain a SCI (2011).

Historically, SCI research has primarily been focused in the areas of pain management, fatigue, wheelchair challenges, and pressure ulcer/seating and positioning challenges (Blanch, Fogelberg, Diaz, Carlson & Clark, 2011; Fattal, Kong-A-Siou, Gilbert, Ventura & Albert, 2009; Hammell, Miller, Forwell, Forman & Jacobsen, 2009; Wearmouth & Wielandt, 2009). However, as occupational therapists, it is important to address the psychological morbidities associated with sustaining a SCI in combination with functional gains. Although there are studies that address quality of life with clients who have sustained a SCI, limited research explores the use of motivation as a deterrent to functional outcomes in clients with SCI (Mortenson et al., 2010).

The authors propose the use of a guide, formulated from an extensive literature review, for occupational therapists working with young male clients who have sustained a SCI. The guide will provide occupational therapists with information on how to motivate clients in order to improve their overall quality of life and ability to engage in occupations. Following a thorough literature review, major concepts were developed which included: Social Support, Therapeutic Relationship, Hope, Peer-Mentoring, and Competitive/Game-Based Interventions. These concepts, in conjunction with assumptions from the Model of Human Occupational and Occupational Adaptation model, were used as cornerstones to developing a guide for practitioners. In utilizing these concepts, occupational therapists can assist in motivating their clients who have sustained a SCI.

Occupational therapists who are interested or currently work in a facility which treats clients with SCIs will have an increased interest in applying this guide into practice. Furthermore, support from administration amongst different facilities will encourage the use of the guide among therapists. Time will also be a factor, which influences the application of the motivation guide. In addition, occupational therapists will need to make time in order to read and become comfortable with the guide and its contents.

In order to investigate the purpose of motivation, theoretical occupation-based models were utilized to formulate and organize different concepts. These models included the Model of Human Occupation (MOHO) and Occupational Adaptation (OA). MOHO was utilized to describe the individual and his *volitional* (motivational) drive (Kielhofner, 2009). Occupational Adaptation describes the internal adaptive process that clients experience when dealing with an occupational challenge (Schkade & Schultz,

2003). In combination, both MOHO and OA incorporate the interaction between the client and his environment (Kielhofner, 2009; Schkade & Schultz, 2003).

The following consists of key terms that will be discussed and utilized throughout this project. These terms are provided to assist in comprehension of this project through the concise use of terminology.

Client: Young male who has sustained a SCI.

Hope: An individual's perception that he has the ability to improve various facets of his life (Kennedy, Evans, & Sandhu, 2009).

Motivation: An individual's drive/desire to engage in activities (Kielhofner, 2009).

Occupation: Everyday activities that one engages in and finds meaningful (American Occupational Therapy Association, 2008).

Spinal Cord Injury (SCI): A life-changing event that affects an individual, physically and psychosocially. It is caused by damage to one's spinal cord, which controls an individual's neurological pathways (Radomski & Trombly, 2011).

Chapter I consisted of a brief introduction to the scholarly project. A synopsis of the literature review is provided in Chapter II.

Chapter II

Review of Literature

Chapter II consists of a review of literature in which the authors provided an overview of spinal cord injuries (SCI) and their prevalence, defined occupation and the role of occupational therapy, and described the influence of a SCI on the individual's occupational engagement in life. The authors further defined and described motivation and evidentiary concepts found to influence motivation. Two theoretical models, the Model of Human Occupation and the Occupational Adaptation model, have also been defined and their assumptions used to interpret published research studies from the perspective of an occupational therapist.

A spinal cord injury (SCI) is a life-changing event that affects an individual, physically and psychosocially (Radomski & Trombly, 2011). It is caused by damage to one's spinal cord, which controls an individual's neurological pathways. As a result the individual is left with many physical changes to which to adapt (adjust), such as the lack of sensation and mobility; both of which occur at the site of the injury and below (Radomski & Trombly, 2011). Psychosocial issues, such as depression and anxiety, are also common following a SCI (Craig, Tran, & Middleton, 2009).

It is estimated that approximately 12,000 people a year sustain a SCI in the United States (NSCISC, 2011). According to the National Spinal Cord Injury Statistical Center (NSCISC), approximately 232,000 to 316,000 people in the United States are living currently with SCIs. SCIs occur most often in males, who account for approximately 80%

of the population of people who have sustained a SCI (2011). In addition, most injuries occur in males, ages 16 to 30 years, making young male adults the largest population who sustain a SCI (2011). Subsequently, for the purposes of this project the authors will refer to young male adults with SCI, as clients, unless otherwise indicated.

It is important to consider SCI recovery as an incredibly diverse and unique experience for each individual as the outcomes of rehabilitation vary from client to client (Radomski & Trombly, 2011). Recovery depends largely on the level at which the injury occurred and whether or not it was a complete or incomplete injury (2011). Complete injuries include a complete lack of sensory and motor activity below the injury, whereas incomplete injuries include partial preservation of sensory and/or motor function below the injury (Radomski & Trombly, 2011). Those who have sustained an incomplete injury have a better prognosis than those who sustained a complete injury (2011). However, recovery of persons with incomplete injuries is less predictable than the recovery of those with complete SCIs (2011).

Not all clients have the same outcomes and each individual's intervention should be developed in accordance with how that client is recovering (Radomski & Trombly, 2011). Whether a client's injury is complete or incomplete, there are many issues of the mind, body, and spirit that need to be addressed and recovery will include many therapies, including occupational therapy. A client's *occupational being* can become altered following a SCI. Occupational being can be described as the relationship between doing (occupation) and being (humanness) (Wilcock, 1993). Moreover, occupations have biological, social, and economic functions that are innate behaviors to human beings

(1993). Occupational therapy (OT) offers clients a rehabilitation experience designed to enhance their abilities to engage in meaningful occupations (AOTA, 2008).

Role of occupational therapy

Sustaining a spinal cord injury has a major impact on an individual's engagement in occupations (Radomski & Trombley, 2011). The physical and psychological impact of an injury, can limit one's participation in everyday purposeful activities (AOTA, 2008; Craig et al., 2009). Due to the effect spinal cord injuries can have on one's occupational being, occupational therapists play a major role in a client's recovery.

Occupational therapy (OT) offers clients a rehabilitation experience designed to enhance their abilities to engage in meaningful occupations (AOTA, 2008). OT incorporates the use of a comprehensive approach when working with clients as it addresses both an individual's emotional/psychological and physical disruption, in his occupations (AOTA, 2008). Occupational therapy focuses on improving a client's ability to become as independent as possible with everyday activities in their environments (AOTA, 2008). This makes occupational therapy a vital profession in which to facilitate a client's recovery.

Occupational therapists look at engagement in occupation from a dual (psychological/physical) and mind, body, and spirit perspective (AOTA, 2008). Therefore, considering the disruptions that can occur with an individual's hope and motivation after a SCI, it is important and essential to start at the volitional core. If done, this can better facilitate the future rehabilitation of the individuals' occupations. Wilcock (1993) wrote the following:

Humans are occupational beings with a need to use time in a purposeful way. People need to make use of their capacities through engagement in individually motivating and ongoing occupations, and if they are able, or encouraged to pursue this need, they will, apart from supplying sustenance for survival and safety, enhance their health (p. 23).

Problem/Purpose Statement

Research within the field of occupational therapy regarding individuals who have sustained a SCI currently provides an ample amount of information in the areas of pain management, fatigue, wheelchair challenges, and pressure ulcer/seating and positioning challenges (Blanch, Fogelberg, Diaz, Carlson, & Clark, 2011; Fattal, Kong-A-Siou, Gilbert, Ventura, & Albert, 2009; Hammell, Miller, Forwell, Forman, & Jacobsen, 2009; and Wearmouth & Wielandt, 2009). There are studies that address quality of life with clients who have sustained a SCI; however, limited research has explored the use of motivation as a deterrent to functional outcomes in clients with SCI (Mortenson et al., 2010). Therefore, the purpose of this project is to produce a guide for occupational therapists providing information on how to motivate young male clients with spinal cord injuries.

Understanding Occupation

According to the American Occupational Therapy Association (2008), occupation is defined as “everyday activity” (p. 628). The term occupation is multi-dimensional, for it encompasses many different areas, (such as, self-care activities, care for others, sleep, education, work, play, leisure, social participation, etc.) meaningful to an individual (AOTA, 2008). Meaningful has been described as significant or important (Forsythe &

Kielhofner, 2003). For the purposes of this project, occupation will be referred to as everyday activities that one engages in and finds meaningful (AOTA, 2008). Moreover, in order to flourish as individuals, humans must have their basic biological needs met through various levels of exercise and development; all of which are performed through occupations (Wilcock, 1993).

Wilcock (1993) provided three major functions for occupation. First, occupations provide basic human needs (food, shelter, and clothing) (1993). For example, the occupations of Activities of Daily Living (ADLs) include bathing, dressing, feeding, and other areas of self-care, which all address basic human needs (AOTA, 2008). Second, occupation assists in skill development, social structures, and engagement in multimedia (1993). For instance, the occupations of social participation, education, and work provide opportunities for individuals to develop skills for participation in everyday activities (AOTA, 2008). Lastly, occupation allows individuals to exercise personal capacities to maintain fulfillment and development throughout their lifespan (1993). For example, the occupations of leisure, play, and work help individuals develop their personal capacities, and uphold fulfillment in their lives (AOTA, 2008). As aforementioned, the three major functions of occupation allow individuals to have purpose and meaning in their lives through engagement in occupations (1993).

Engagement in occupation is vital to a client's well-being. Healthcare researchers have explored the effects of sustaining a SCI and found that *occupational loss* occurred physically and psychologically (Chan, Lee, & Lieh-Mak, 2000; Craig et al., 2009). Occupational loss can be described as a disruption or loss in one's meaningful every day activities. Feelings of hopelessness, depression, and being a burden for others have been

identified as common in clients (Chan et al., 2000; Craig et al., 2009). In addition, physical disruptions in being able to complete ADLs such as bathing, dressing, and grooming may occur (Chan et al., 2000; Craig et al., 2009). When physical or psychological disruptions in occupations occur, clients may experience occupational loss (Chan et al., 2000; Craig et al., 2009).

Humans are occupational beings and the occupations in which they engage in, physically or mentally, shape who they are (Kielhofner, 2009). When a disruption occurs, clients' identities can be compromised. As a result, *quality of life* is negatively affected in clients (Wilcock, 1993). Quality of life has been described as how clients live, the joy they find in activities, and their ability to engage in life (Hinojosa, Kramer, Royeen, & Luebben, 2003). However, it is important to identify that quality of life can have different meanings for different people. Therefore, it is essential that occupational therapists address each client's individual needs from a mind, body, and spirit perspective (AOTA, 2008).

Over the years, individuals have explored the ways in which adults learn, how people can learn through observation, how people learn new information, and how people learn through various ways of teaching and learning (Kielhofner, 2009). There are many theories that purport that *motivation* is a part of the way individuals learn and engage in occupations. These theories have been described throughout this literature review and serve as a foundation for exploring and addressing the role of motivation with clients who have experienced occupational loss following a SCI.

Motivation in occupational engagement.

For the purposes of this project, motivation will be referred to as an individual's drive/desire to engage in activities (Kielhofner, 2009). The role of motivation influences engagement in occupation by allowing a client to see opportunities and challenges in his life, what he chooses to do in his life, and how he experiences and makes sense of his occupations (Kielhofner, 2009). After sustaining a SCI, several psychosocial factors of clients are influenced, making the role of motivation an essential component to address in occupational therapy.

Depression and anxiety are two psychosocial factors that clients with SCI may experience (Craig et al., 2009). The inability to engage in everyday occupations often results in a tremendous amount of perceived psychological stress (Craig et al., 2009). Often clients with SCIs are young males entering adulthood who are engaged in several occupations (Randomski & Trombley, 2011). The effects of a SCI limits their engagement in occupations and areas of their lives; occupations which often contribute to their sense of self and perceived life roles. As a result, this can lead to depression and anxiety symptoms (Craig et al., 2009). By exploring the role of motivation, occupational therapists may design interventions intended to counteract these psychological morbidities and play an important part to client-centered treatment within the field of occupational therapy.

Motivation and the Model of Human Occupation.

The term motivation is synonymous with the term *volition*, as used in the Model of Human Occupation (MOHO) model (Forsyth & Kielhofner, 2003). MOHO is an occupation-based and client-centered model, developed within the occupational therapy profession, and includes three core areas: *Volition*, *Habituation*, and *Performance*

Capacity (Kielhofner, 2009). Forsyth and Kielhofner (2003) referred to volition as “a person’s inner characteristics which interact with the environment to create a network of conditions that influence how one is motivated, what one does, and how one performs” (p.48). As motivation and engagement in occupation are core areas in this project, MOHO will be described throughout as it promotes the incorporation of these two concepts (Kielhofner, 2009). In addition, for the purposes of this project, motivation will be referred to as an individual’s drive/desire to engage in activities, and therefore, is a central aspect to client rehabilitation in occupational therapy (Kielhofner, 2009).

Volition incorporates an individual’s *personal causation, values, and interests* (Cole & Tufano, 2008). Personal causation refers to a client’s ability to feel competent or effective in regards to his control over a situation (Cole & Tufano, 2008). Values are a client’s attitude or viewpoint regarding what is right and wrong, his principles, and his beliefs (2008). Interests are people, objects, and/or ideas that are important to a client (2008). These three concepts form volition and are applied in the following example. Thompson, Coker, Krause, and Henry (2003) surveyed clients with SCI to determine how one’s purpose in life influences adjustment following injury. The authors concluded that clients constantly search for purpose in life as a means of coming to term with reality of the disability (Thompson, Coker, Krause, & Henry, 2003). Ways clients achieved this state in recovery included using humor to look at the new difficulties (interests), identification of values and choices made, and finding a balance between the “I am” and “I can” mind frame (personal causation), in hopes of mediating adjustment following SCI (Thompson et al., 2003).

Volition calls for a drive to action (Kielhofner, 2009). Molton, Jensen, Nielson, Cardenas, and Ehde (2008) conducted a research study to assess the effectiveness of the *Motivational Model of Self-Management* for clients with SCIs. The authors of this model highlighted motivation as an end pathway to coping (Molton, Jesnsen, Nielson, Cardenas& Ehde, 2008). The authors asserted that motivation was thought to be influenced by the client's perception of the importance of intervention (value) and belief in oneself (personal causation) (i.e. the client's perception of being able to participate effectively in the intervention) (Molton et al., 2008). Subsequently, the perceived importance of motivation was positively correlated with heightened exercise behaviors in clients (Molton et al., 2008). Forsyth and Kielhofner (2003) proposed that if clients are motivated, they are more likely to engage in occupation and that "occupation is essential because by doing things, people shape who they are" (p. 48).

As previously described, the inability to engage in everyday occupations can result in a tremendous amount of perceived psychological stress in clients (Craig et al., 2009). The effects of a SCI can limit client engagement in occupations and result in decreased volition (motivation) (Craig et al., 2009; Kielhofner, 2009). Forsyth and Kielhofner (2003) stated, "therapy is viewed as a process in which people are helped to do things in order to shape their abilities, self-concepts, and identities" (p.48). A disruption or lack of attention to motivation can lead to negative psychosocial symptoms and may result in the need for occupational therapy (Craig et al., 2009). Some negative psychological states that have been researched as a result from SCI include: anxiety, distress, post-traumatic stress disorder (PTSD), loss of control, helplessness, and decreased quality of life (Craig et al., 2009). Craig, Tran, and Middleton (2009) asserted that exploring the role of

motivation would counteract these psychological morbidities and play an important part to client-centered treatment, as viewed in MOHO's central concept of volition.

Volition is composed of three underlying factors that provide substance to a client's reasons for pursuing occupations (Kielhofner, 2009). The first underlying factor to volition is personal causation, which explains an individual's own thoughts and feelings regarding one's self-efficacy while participating in occupations (2009). For the purposes of this project, self-efficacy will be defined as beliefs about a client's ability to engage in occupation. Occupational therapists should encourage both a client's intrapersonal motivation and strive for autonomy in order to increase his self-efficacy (Philippe & Vallerand, 2008). Autonomy can be defined as being self-initiating in regulating one's own actions (2008). Philippe and Vallerand examined the effects of one's self-determined motivation. The authors' findings supported the idea that self-determined motivation provided a positive impact on client autonomy and satisfaction levels. Furthermore, clients were more likely to be self-determined when they had freedom of choice (2008).

Self-efficacy is an important factor that is positively correlated to the follow through of behaviors (Molton et al., 2008). In occupational therapy, this is similar to personal causation. Forsyth and Kielhofner (2003) indicated that personal causation is "reflected in our awareness of present and potential abilities and our sense of how able we are to bring about what we want" (p. 50). Moreover, having increased self-efficacy can lead to an increased participation in occupation (2008). Cumulatively, thoughts and feelings about enjoying, valuing, and feeling competent are at the core of volition (2003). Furthermore,

disruptions with personal causation, interests, and values can lead to a breakdown in morale and motivation in an individual (2003).

After sustaining a SCI, several psychosocial factors of young adult males are impacted, making the role of motivation an essential component to address. The role of motivation influences engagement in occupation by allowing people to see opportunities and challenges in their life, what they choose to do in their life, and how they experience and make sense of their occupations (Kielhofner, 2009). MOHO highlights the significance of an individual's motivation, to perform occupations (2009). The ultimate goal of MOHO is to explain the reasoning behind an individual's engagement in occupations through their volition, habituation, and performance capacities (2009). However, despite the prevalence of MOHO in occupational therapy literature, more research is suggested to explore the usefulness of motivational factors and techniques in occupational therapy with young male adults who have sustained a SCI.

The role of hope in motivation.

Hope is a term that is often used during a difficult time in one's life, such as a hospital stay after an injury. Lohne and Severinsson (2004) defined hope as the probable orientation towards approaching improvements. In another study in which researchers assessed how hope can influence client's rehabilitation following SCI, hope was described as a positive perception and belief that persons can engage in and achieve their goals (Kennedy, Evans, & Sandhu, 2009). For the purpose of this project, hope will be defined as the client's perception that he has the ability to improve various facets of his life in the future.

In a phenomenological study, Lohne and Severinsson (2004) explored hope and meaning experienced by patients who were in acute phases of a SCI at a Norwegian rehab hospital; a hospital that identified *installation of hope* as a core value. Each client was interviewed regarding his or her views on hope during the recovery period (2004). Due to the occupational loss experienced after a spinal cord injury, Lohne and Severinsson identified hope as a natural response (2004). Moreover, clients valued their hopes of return to the previous occupations they once engaged in such as walking, dancing, and running, among many other daily activities (2004).

When present, hope can play an important role in clients' recovery and should be addressed in occupational therapy evaluation and intervention (Kennedy et al., 2009). Hope provides a positive outlook on the future, leaving an optimistic belief that a situation can improve (Kennedy et al., 2009). If hope is addressed, clients can be motivated towards the engagement in interventions. The absence of hope, however, can be detrimental to the clients' recovery processes.

According to Craig et al. (2009), negative mood or depression leads to increased risk of poor psychological outcomes. If a client does not have the belief that his situation may improve, finding motivation to continue with therapy will be difficult. Kennedy, Evans, and Sandhu (2009) observed a positive correlation between hope and a client's motivation. The authors of the study noted that the more hope and motivation/desire a client had to engage in activities, the better a client was able to cope with injury (Kennedy et al., 2009). In addition, the client hoped to improve throughout treatment in order to regain independence in occupations (Lohne & Severinsson, 2004). The loss of independence in occupations can assist in motivating client engagement in interventions,

with the hope that he can gain back his independence in occupations (Lohne & Severinsson, 2004).

Since hope may assist in motivating clients, lower levels of depression were linked to clients who had a high sense of hope (Kennedy et al., 2009). By having a positive outlook during the recovery period, clients were less likely to experience high levels of depression (Craig et al., 2009; Kennedy et al., 2009). It is important for therapists to explore different ways to promote hope for clients. Furthermore, authors of the following study explored the method of peer-mentoring in assisting clients in building hope.

Hope and peer-mentoring.

Ljungberg, Kroll, Libin, and Gordon (2010) explored how clients with SCIs are affected (either negatively or positively) by the use of a peer-mentor program. Peer mentoring has been described as a relationship between two people who share similar experiences (i.e. SCI) and support and help each other. There has been anecdotal evidence that has supported the concept that peer mentoring assists clients with SCIs as a way to inspire and direct them, as well as improve their physical and psychosocial health. Whahman, Biguet, and Richard (2006) revealed that a client measuring his recovery in relation to the recovery of another was a driving motivational force. Peer-mentoring programs provide clients with the ability to interact with individuals who have gone through the recovery process, installing hope (Lohne & Severinsson, 2004). Clients are able to see engagement in activities and ask questions about how past clients participated in their recovery, allowing clients to hope for future improvements. In addition, Whahman et al. (2006) indicated that having a role model and/or being a role model was a major motivating factor to keep clients engaged in physical activities.

Hope is an important factor to instill in clients. However, the concept should be used with caution. Lohne and Severinsson (2004) indicated, in some instances, that hope can negatively affect a client. For example, if one stops making improvements as he or she had hoped, the client may be impacted greatly by the lack of progress. A client may become overly focused on future improvements instead of dealing with present struggles. According to Kennedy et al. (2009), hope was less effective than cognitive appraisals when clients were adjusting to continuous anxiety and depression following a SCI. This finding supports the idea that although it is important for a client to have and continue to hope, he should also remember to address his current health situation (Kennedy et al., 2009). To adapt successfully following an injury, it is important that the client maintains a balance between his present progress in recovery and his hope for the future (Thompson et al., 2003). A client can achieve this balance and maintain it, by his ability to adapt to psychological or physical disruptions in his occupations.

Motivation and Occupational Adaptation.

Occupational Adaptation (OA) refers to the process and interaction between the client and his occupational environment (Cole & Tufano, 2008). Occupational Adaptation consists of four main constructs: *Occupation*, *Adaptive Capacity*, *Relative Mastery*, and *Occupational Adaptation* (Cole & Tufano, 2008). Occupations are activities that actively involve the client, are meaningful, and involve a process rather than product (Cole & Tufano, 2008). Adaptive capacity is the capability a client has to perceive the need to change, modify, or refine a response to occupation (Schkade & Schultz, 2003). Relative mastery refers to when a client evaluates efficiency, effectiveness, and satisfaction of participation in occupation (Schkade & Schultz, 2003).

Lastly, OA describes the process that occurs when a client experiences a challenge, or disruption, as a result of the interaction between the client and his environment (Schkade & Schultz, 2003).

Function is achieved in OA when a client is able to participate within his environment with a sense of mastery and accomplishment (Cole & Tufano, 2008). Every day, a client experiences a desire, demand, and press for mastery when engaging in his occupations (Schkade & Schultz, 2003). This demand and press for mastery can be applied in competition and its relation to motivation. Whahman et al. (2006) explored the themes relating to motivation after a SCI injury. In their results, they found correlations between motivation and competition, motivation and role modeling, and motivation and gaining independence (Whaman et al., 2006). Whaman et al. (2006) indicated that clients were more motivated to get better by competing with their peers. If competition was present, motivation was positively correlated (Whaman et al., 2006).

In Occupational Adaptation, the person strives for mastery which can be seen in the relationship between motivation and competition (Schkade & Schultz, 2003). Furthermore, participants identified that measuring oneself up to others around them was a driving motivational force (Whahman et al., 2006). Guidetti, Assaba, and Tham (2009) indicated that seeing other patients go through the same process was motivating for the participants (Guidetti, Assaba, & Tham, 2009). In addition, when clients were challenged just the right amount to complete self-care tasks, the clients became more attentive to their difficulties and more inclined to attempt future tasks (Guidetti et al., 2009). This theme demonstrated that the more improvements made by clients, the more clients would challenge themselves (Guidetti et al., 2009). As seen in occupational

adaptation, it is important to work with clients to address their adaptive capacity in hopes of reaching relative mastery (Schkade & Schultz, 2003).

According to OA, a client will be motivated to change if the occupation is meaningful to him, the client is able to adapt to the demands of the occupation, and the environment demands match the client's ability to adapt (Cole & Tufano, 2008). The occupational environment includes the physical, social, and cultural influences (Cole & Tufano, 2008). Client's participation takes place within these different environments, which all have various demands for mastery (Cole & Tufano, 2008). A client will confront his perception of an occupational challenge, in order to meet the demands of both himself and his environment, through adaptive response behaviors (Schkade & Schultz, 2003).

Disruptions that occur within a client's occupations represent the client being challenged to change his life roles and functioning and take on an adaptive response behavior (Schkade & Schultz, 2003). There are three categories to adaptive response behaviors: primitive, transitional, and mature (Schkade & Schultz, 2003). Clients in the primitive response are typically frozen by the occupational challenge and do not produce any movement that can progress to adaptation (2003). Clients in the transitional response produce a great deal of activity, though the activity is random and variable (2003). However, clients' behaviors in the transitional stage are more likely to lead to adaptation than behaviors occurring in primitive response (2003). Lastly, clients in the mature response are goal-directed and most likely to produce not only an adaptive response, but a masterful one (2003).

According to the theory of occupational adaptation, the relationship between a person and his environment is observed during occupational role functioning (Cole & Tufano, 2008). Occupational role functioning is influenced by a client's internal perceptions of how he should act according to himself, and how he should act according to the social and cultural norms (Cole & Tufano, 2008). For instance, when a client participates in an occupation, he can be influenced by his environment and the specific role expectations within it which influences his adaptive response behaviors (Cole & Tufano, 2008).

Guidetti et al. (2009) explored the process and context behind relearning the ability to complete self-care tasks for clients with SCIs in acute care. Context not only encompassed the environment and time, but also the perception and experience a client had with an occupation (Guidetti et al., 2009). This concept is displayed in the occupational role functioning in the environment of social and cultural norms (Cole & Tufano, 2008).

Fulfilling an occupational role can be applied in role modeling and peer-mentoring programs. Whahman et al. (2006) found that participants valued either having a role model or being a role model as a motivating factor to keep engaged in physical activity, with emphasis on a positive attitude. The benefits of peer-mentoring or a role model appears to be a useful method in providing clients with support to adapt positively by fulfilling a sense of mastery within occupational role functioning (Cole & Tufano, 2008).

Peer mentoring can be described as a relationship between two people who share similar experiences (i.e. SCI) and support and help each other. Ljungberg et al. (2010)

explored how clients with SCIs were affected (either negatively or positively) by the use of a peer-mentor program. Participants relayed the benefits from interacting with others who had experienced a similar loss and gone through the same process (Ljungberg et al., 2010). It gave the participants motivation to continue with the rehab process and have a positive psychosocial outlook on their quality of life (Guidetti et al., 2009; Ljungberg et al., 2010). Whether it was through role modeling or peer mentoring, clients were motivated by having an occupational role (Cole & Tufano, 2008; Ljungber et al., 2010). This occupational role fulfillment can provide the ability for clients to feel confident and work towards a higher life satisfaction and mastery according to OA (Cole & Tufano, 2008).

Heckhausen, Wrosch, and Schulz (2010) conducted life-span development research on the adaptive capacity individuals have to optimize development across major changes in a lifetime. The core feature of the adaptive capacity that the authors referred to was motivation (Heckhausen, Wrosch, & Schulz, 2010). A key component to motivational life-span theory is adaptation and the extent to which people control their own environments across a lifetime and are motivated to achieve the effects in their environment (Heckhausen et al., 2010).

Function is achieved in OA when a client is able to participate within his environment with a sense of mastery and accomplishment (Cole & Tufano, 2008). Heckhausen et al. (2010) found that this adaptive capacity between person and environment created a motivational commitment. The authors of the motivational theory of development addressed a balance that helped one select appropriate goals and know

when to compensate for failures, setbacks, and/or losses (Heckhausen et al., 2010).

Mackay, Charles, Kemp, and Heckhausen (2010) also attested to this balance.

Mackay et al. (2010) utilized the Life-Span Theory of Control to examine goal engagement in adults living with spinal cord injury. Important concepts that Mackay et al. (2010) utilized from this theory included: (1) disengaging from goals that are unattainable is a vital component to healthy functioning, (2) selecting of alternative goals after disengagement from unattainable goals relates to higher levels of affective well-being, and (3) refusing to accept failures can eliminate motivation to seek new and attainable goals (Mackay, Charles, Kemp, & Heckhausen, 2010). These concepts are similar to the aforementioned adaptive response behaviors that clients go through in occupational adaptation (Schkade & Schultz, 2003).

If a client is able to adapt to psychosocial and/or physical disruptions in occupation, then he is able to engage in occupations and have hope. If hope is addressed with the client, he can be motivated towards the engagement in occupations, with the hope that his situation can improve. It is important that occupational therapists deal with all of a client's needs during recovery from a SCI. The utilization of specific models and theories provide therapists with a grounded and guided approach when providing interventions. Occupational therapists are skilled in both MOHO and OA to address the needs of the client's mind, body, and spirit.

Environmental considerations for occupation

According to MOHO, environment includes physical and social aspects. Either the physical or social aspect of an environment can promote or limit occupational engagement (Forsyth & Kielhofner, 2003). Client's environments have a major impact during the recovery period after sustaining a SCI. Heckhausen et al. (2010) described

the clients control over their environment and the role it played in clients' recovery.

Primary control capacity is referred to as an individual's ability to influence outcomes within their own environment (Heckhausen et al. 2010). Thus, the more control a client has over his environment, the more likely he is to engage in activities and maintain a positive motivational state (Heckhausen et al. 2010). This concept relates with the environment assumption of model of OA in which environment can place a demand or challenge on the client (Cole & Tufano 2008).

Thompson et al. (2003) identified that clients who were more socially involved and actively participated in interventions had positive associations to purpose in life. The authors indicated the importance of maintaining a strong social relationship with the therapist and the influence the relationship had regarding a client's reason for engagement in occupations of life (Thompson et al., 2003). The therapeutic relationship can be described as an enabling relationship, assisting clients to engage in occupations (Guidetti et al., 2009). The positive social environment that is present in a therapeutic relationship allows the therapist to challenge and motivate clients to engage in occupations that even clients thought were not possible (Guidetti et al., 2009). In a study conducted by Guidetti et al. (2009), a theme (*air of expectation*) emerged in which it was expected that the clients would complete self-care tasks by themselves. In doing so, therapists challenged their clients to engage in activities, even if clients were unsure if they could complete those activities (Guidetti et al., 2009). This therapist guided challenge from the therapist can be viewed as an environmental demand. Furthermore, when a client is able to participate within his environment with a sense of mastery and accomplishment, function can be achieved (Cole & Tuffano, 2008). The air of

expectation motivated clients to be more independent and they were more inclined to identify personal weaknesses, attempt to complete tasks independently, and meet the demands of the environment (Guidetti et al., 2009).

Guidetti et al. (2009) identified the need for assistance from others as helpful during their recovery. Clients reported that it was enjoyable to have someone provide emotional and psychological support (Guidetti et al. 2009). Furthermore, clients who were more socially involved and actively participated in interventions had positive associations to purpose in life (Thompson et al., 2003). In addition, a strong social support system was indicated to be an important factor in maintaining engagement in physical activities (Whahman et al., 2006). Kehn and Kroll (2009) identified having social support as a factor that could promote engagement in physical activity. Social support may also be found through the utilization of role-modeling (Whahman et al., 2006). “The opportunities to see someone with a similar disability manage a physical activity that previously was thought impossible provides concrete proof and a conception of the possibilities.” (2006, p. 484)

Chan, Lee, and Lieh-Mak, (2000) highlighted the stresses of family relationships after a client’s injury. Clients may believe that they have become a burden to their family, because of the extra assistance they require. Relationships can strain and cause stress between clients and their spouse and/or family (Chan et al., 2000). Mortenson, Noreau, and Miller (2010) identified familial support (social environment) as having an important influence on a client’s quality of life. Therefore, it is important that the client is able to find a balance between the demands of the social environment and the interaction of

relationships during his recovery to positively influence quality of life (Mortenson, Noreau, & Miller, 2010).

The physical environment also has an impact on the recovery of a client following a SCI. As asserted in MOHO, the environment encompasses the physical and social environments and the person and their environment are inseparable (Forsythe & Kielhofner, 2003). Therefore, the environment should be explored for potential barriers and facilitators. As Whaman et al. (2006) found, environments that are accessible promoted engagement in exercises. Barriers to engagement in physical activities included a lack of accessibility, whether it was the facility, or the travel needed in order to gain access to a facility (Kehn & Kroll, 2009). Therefore, it is important to consider accessibility to physical environments in promoting engagement in activities to those recovering from SCI. Scelza, Kalpakjian, Zemper, and Tate (2005) also identified that a lack of physical accessibility to exercise areas inhibits engagement in activity. Likewise, even if exercise machines were accessible, it was important to have competent faculty to assist the clients with engagement in activities (Scelza, Kalpakjian, Zemper, & Tate, 2005). The more accessible an area is environmentally and socially, the more likely clients are to engage in occupations.

Motivation Interventions and Assessments

Use of formal assessment and interventions that specifically address motivation within the field of occupational therapy is limited. Furthermore, Carlson (1997) evaluated how occupational therapists, working in physical disability settings, evaluated client motivation.

The researcher surveyed fieldwork coordinators regarding common evaluation procedures therapists utilize to address motivation (Carlson, 1997). Carlson (1997) revealed that (93%) of therapists evaluated motivation informally. In addition, 93% agreed that motivation had an influence regarding treatment. Moreover, 88% of therapists reported that assessing motivation actually improved treatment outcomes (Carlson, 1997). The model therapists utilized most often to address motivation was MOHO. Lee, Taylor, Kielhofner, and Fisher (2008) surveyed therapists that utilized MOHO and discovered approximately 92% of them understood volition (motivation). The therapists indicated that although the concept was easy to explain and utilize with their clients, therapists only used formal MOHO-based assessments with half of their clients, and that MOHO assessments sometimes were too complicated for clients (Lee, Taylor, Kielhofner, & Fisher, 2008).

Therefore, the use of formal assessments to evaluate client motivation would be a beneficial inclusion in a program for motivation of clients with SCIs.

The Therapeutic Relationship.

Occupational therapists have an important role in exploring the person, environment, and occupation (Forsyth & Kielhofner, 2003). This can include assessing the social environment and how interventions are implemented within them. The therapeutic relationship supports honest and clear communication between client and therapist. When providing treatment, therapists can also play a challenging and motivating role. Guidetti et al. (2009) suggested that therapist can challenge clients to perform occupations, whether or not the client believes he can perform it. Therapists can do this through verbal and non-verbal methods in which therapists provide an air of

expectation (Guidetti et al., 2009). Occupational therapists will expect clients to engage in all occupations as independently as possible. In doing so, clients attempt to engage in occupations; they may otherwise not have thought to have attempted (Guidetti et al., 2009). By challenging clients, therapists are motivating them to engage in occupations, attempting to increase their level of independence. Through utilizing the air of expectation method, clients become more attentive to their difficulties and more inclined to attempt tasks (Guidetti et al., 2009).

The therapeutic relationship continues to have a significant impact during the implementation of interventions during a client's recovery. It is important for clients to feel as though they have a crucial role with the decision-making process during their recovery. As described by Schkade and Schultz (2003), the client is the *agent of change* (p. 209) and the occupational therapist works as a facilitator with the process. Moreover, it is important that clients engage in decision making and the goal making process (Philippe & Vallerand, 2008).

Mackay et al. (2010) showed that clients' engagement in goal making had a positive impact on their therapy participation. Guidetti et al. (2009) indicated that clients thought of the recovery as a process that the client experienced together with the occupational therapist. When creating goals, or choosing occupational goals, the clients would refer to it as "we" decided, indicating that the therapist and client had an equal investment in the clients' recovery (Guidetti et al., 2009). By involving the clients in the goal making process, they are thought to be more invested and have improved quality of life (Mackay et al., 2010). Clients have increased motivation to engage in therapeutic interventions when they are a part of the goal-making process. Thompson et al., (2003)

indicated that more social engagement and participation within therapeutic interventions related to an improved feeling or purpose of life for clients.

Technology.

American culture continues to make improvements in technology; occupational therapists should strive to create new intervention methods that utilize technology. As changes occur within the field of occupational therapy and the needs of clients change, it is important that occupational therapists identify evidence-based practices supporting new use of multi-media therapy techniques. Engagement in video-games and other types of multi-media is popular among young males. Betker, Desai, Nett, Kapadia, and Szturm (2007) studied the effectiveness of game-based interventions that worked on improving clients balance and seating posture. The results indicated that the clients enjoyed the interventions and were motivated to complete them (2007). Not only did the clients enjoy participating in the intervention, but they also found them challenging which motivated them towards a continued recovery (2007). An important finding was that each participant decreased his fall rate after engaging in the COP video-game based exercise (2007). Betker et al. (2007) provided support for the effectiveness of game-based activities to improve occupational engagement outcomes.

Client Self-Efficacy, Hope and Social Support.

Mortenson et al. (2010) identified the positive effect that a client's positive self-efficacy has on his quality of life and recovery. As aforementioned self-efficacy is the belief a client has about his abilities to engage in occupations. An important intervention strategy for occupational therapists is to improve their clients' self-efficacy. In doing so, clients' motivation, self-determination, and strive for independence will improve. Self-

determined motivation provides a positive impact on client's independence and level of satisfaction (Philippe & Vallerand, 2008). By providing challenges that a client can attempt, and master, therapists are building a client's beliefs about his capabilities (confidence), increasing the client's engagement in occupations. If a client has increased self-efficacy, he is more likely to engage in activities (Molton et al., 2008).

The thought that a client's situation has the ability to improve (i.e. hope) is a motivating factor eliciting engagement in occupations. As occupational therapists, it is important to provide clients with hope to assist with increasing their engagement in occupations. If a client had no hope, what would be his purpose for participating in interventions?

According to Lohne and Severinsson (2004), hope serves as a motivating factor, for a client to regain his independence after sustaining a SCI. Occupational therapists should promote a positive outlook on client's recovery to support engagement in occupations. Simultaneously, occupational therapists should remember to focus on factors that are affecting the client at his current phase in recovery. A client may become upset if he experiences a pause toward improvements, resulting in a negative impact on hope (Lohne & Severnsson, 2004). In return, it is important that occupational therapists promote hope while having the client work on current barriers impacting his engagement in occupations. The more hope and motivation a client has to participate in occupations, the more his ability to cope with injury is improved (Kennedy et al., 2009).

Occupational therapists can assist in promoting hope, while also providing social support to clients through the development of a peer-mentoring program during a client's recovery. By providing a role-model for a client, occupational therapists provide clients

with motivation for increased engagement in physical activities (Whahman et al., 2006). By comparing their recovery to the recovery of others, clients were motivated to continue engagement in activities, to improve, and become more independent (Whahman et al., 2006). Therefore, occupational therapists can have a major impact on creating and implementing peer-mentoring programs in order to assist clients' motivation levels and overall recovery after sustaining a SCI.

Formal Assessment.

The ability to evaluate the effectiveness of a method or procedure crucial to a program/intervention method and measuring a client's success. The effects of motivation are important as the purpose of this project is to provide clinicians with a guideline on how to motivate young male clients with spinal cord injuries and a number of assessments may be used to assess the motivation of clients.

The *Volitional Questionnaire* (VQ) is used to assess a client's volition (motivation) in different environments and to understand the role of the environment (Kielhofner, 2009). This assessment is performed through therapist observation and used to examine a client's level of volition. The reliability and validity of the Volitional Questionnaire has been well researched and found to be reliable and valid (Chern, Kielhofner, Carmen de las Heras, & Magalhaes, 1996). Assessment with the Volitional Questionnaire should be completed both at the referral to occupational therapy and discharge from occupational therapy to examine the role or effectiveness of the guideline on a client's level of motivation and whether or not client's motivation levels increased.

The *Functional Independence Measure* (FIM®) assessment is also a useful tool in assessing the client motivation and his functional outcomes while engaging in

occupations. A pre and post FIM® assessment could be used to examine whether a client benefited functionally from a motivational guideline implementation. The FIM® has been researched to have good validity and reliability (Deutsch, Braun, & Granger, 1997; Hamilton, Laughlin, Fiedler, & Granger, 1994; Ottenbacher, Hsu, Granger, & Fiedler, 1996).

The *General Self-Efficacy* (GSE) scale may be used in order to assess how clients view their capabilities to complete tasks (Schwarzer & Jerusalem, 1995). This scale has been translated in more than 20 languages and has been published in over 1,000 research journals (Schwarzer & Jerusalem, 1995). The GSE has been researched as both a reliable and valid instrument (Luszczynska, Gutiérrez-Doña, & Schwarzer, 2004; Scholz, Gutiérrez-Doña, Sud, & Schwarzer, 2002).

Chapter II Summary

As previously discussed, Wahman, Biguet, and Levi (2006) indicated that motivation is a key factor to increasing client participation in activities. By engaging in activities, clients are either improving or maintaining health and preventing secondary conditions. According to research findings, a major problem for clients with SCIs in therapy was participation lack of motivation (Chan et al., 2000; Craig et al., 2009; Kennedy, Evans, & Sandhu, 2009; Lohne & Severinsson, 2004), which ultimately leads to lack of occupational engagement and subsequent recovery.

From existing evidence five concepts were found to positively impact client motivation. These concepts were: Social Support, Therapeutic Relationship, Hope, Peer-Mentoring, and Competitive/Game-Based Interventions. Furthermore, evidence has indicated the therapeutic and occupational benefits of addressing motivation. In addition,

occupational therapy theoretical models emphasize the importance of a client's roles, their environment, and how they engage in occupations.

Despite the documented importance of motivation, there are limited established occupational therapy guidelines for using motivation as an intervention for clients who have sustained a SCI. In conclusion, we anticipate that a guide for occupational therapists to address clients' motivation in SCI recovery will increase clients' participation in activities to increase overall quality of life.

Chapter II consisted of the literature review and background information regarding past SCI research. In addition, theoretical models were analyzed to formulate the methods on how to structure and develop the product. Chapter III, Methodology, consists of the detailed information on how the product was created.

Chapter III

Methodology

Chapter III consists of the methods used to develop this scholarly project. Specifically, this chapter contains information regarding the origin of the idea, the process of the literature review, the use of occupational therapy theory to interpret and guide the development of *Motivation: An Occupational Therapist's Guide for Young Male Clients with Spinal Cord Injuries*, and an overview of the final product.

This product was designed from the authors' shared passion and interest regarding motivation in occupational therapy and the use of it in designing interventions for clients who have sustained a SCI. At the time this scholarly project was written, one of the authors was a young adult male who sustained a SCI while in high school. Through the recovery process, that author experienced several different challenges that often accompany a SCI and subsequently developed a deep understanding of both the psychosocial and physical impacts of sustaining a SCI. The author's experience was used as a foundation for ideas to enhance motivation in clients with similar injuries; ideas that were substantiated, later, through review of published evidence. Through the exploration and integration of literature and the lived experience of SCI, the authors intended *Motivation: An Occupational Therapist's Guide for Young Male Clients with Spinal Cord Injuries*, to serve as a measure to address motivation, to increase overall quality of life through engagement in occupations.

A thorough literature review was conducted to explore the physical and psychological effects of clients who sustained a SCI, the role of motivation in the recovery of clients with SCIs, and theoretical foundation of motivation and occupational engagement. The literature review was conducted utilizing several search engines. These included Academic Search Premier, Cumulative Index to Nursing (CINAHL), Google Scholar, and PubMed databases, which were accessed through Harley E. French Library of the Health Sciences, at the University of North Dakota School of Medicine and Health Sciences. In addition, literature was located from the National Spinal Cord Injury Statistical Center (NSCISC) and the Christopher Reeve Foundation.

A search for evidence regarding motivation for clients with SCIs resulted in little information. While a plethora of research exists on rehabilitation for clients with SCI, most is directed toward physical recovery and related processes. The literature review indicated a lack of exploration on the role of motivation in recovery of clients with SCI and limited useful clinical information for occupational therapy clinicians seeking to address motivation in clients with SCIs. The dearth of cohesive guidelines regarding motivation illustrated a need for the development of a guide for clinicians working with clients with SCI. As males have been well documented to sustain the highest number of SCIs when compared to females, we chose to develop this product for young males, though the guidelines could be adapted for female clients.

Assumptions from Model of Human Occupation (MOHO) and Occupational Adaptation (OA), two occupational therapy theoretical models, were used to both interpret existing literature from an occupational therapy viewpoint and also to design the *Motivation: An Occupational Therapist's Guide for Young Male Clients with Spinal Cord*

Injuries. MOHO was utilized to capture the breadth of an individual at their *volitional* core. Through the exploration of theoretical concepts that encompass MOHO, the authors utilized MOHO to develop an occupational profile and assessment portion to the clinical guide (Forsyth & Kielhofner, 2003). In combination with MOHO, the authors utilized Occupational Adaptation (OA) to depict the internal adaptive process that clients go through when faced with an occupational challenge (Schkade & Schultz, 2003). Furthermore, both MOHO and OA were utilized to understand the interaction between the client and his environment. As a result, the development of this guide illustrates the process that occurs when a client experiences a challenge, or disruption, as a result of the interaction between the client and his environment (Schkade & Schultz, 2003).

The guide utilizes three assessments to assess motivation and function related to sustaining a SCI. These assessments include the Functional Independence Measure (FIM®), Volitional Questionnaire (VQ), and General Self-Efficacy Scale (GSE). Concepts were created in order to address lack of motivation based on the theoretical models, the literature review and assessment foci. Five concepts were found in existing literature to positively impact client motivation. These concepts were: Social Support, Therapeutic Relationship, Hope, Peer-Mentoring, and Competitive/Game-Based Interventions. The authors of this guide developed interventions to explore each concept in order to enhance clients' motivation during SCI recovery.

Using available evidence and occupational therapy theoretical models, the authors designed an intervention guide for occupation therapists to use when working with young males with SCIs. Overall, through the comprehensive literature review, personal experience of one of the authors, incorporation of theory and occupation, motivation is an

essential component to the recovery of individuals living with SCI. The clinician's guide has been developed with the use of occupation-based models, validated assessments, peer-reviewed research, and application of how to address motivation, in order to increase overall quality of life (psychosocial and physical health) through engagement in valued occupations. The guide can be used in conjunction with traditional occupational therapy interventions to promote clients' motivation, prevent loss of hope, and for those who are already experiencing barriers to motivation. The authors developed a product intended to empower clients to participate in their valued occupations by addressing and enhancing the core area of motivation.

Chapter III, Methodology, consisted of descriptions of the origin of the project idea, the process of the literature review, and the use of occupational therapy theory to interpret and guide the development of *Motivation: An Occupational Therapist's Guide for Young Male Clients with Spinal Cord*. Chapter IV is comprised of the product description. The product was developed with the use of occupation-based models, validated assessments, peer-reviewed research, and application of how to address motivation, to increase overall quality of life through engagement in occupations.

Chapter IV

Product

Chapter IV is comprised of a brief description and summary of the product of this scholarly project. The full guide can be found in the appendix of this scholarly project.

The purpose of this project was to develop a guide for occupational therapists about how to motivate young male clients with spinal cord injuries. The product *Motivation: An Occupational Therapist's Guide for Motivating Young Male Clients with Spinal Cord Injuries* was created for use during a client's recovery period at an in-patient rehabilitation facility. The content was structured utilizing available evidence and occupational therapy theoretical models. The available evidence and theoretical models organized main focal points of the guide and are depicted throughout figures and visual dialog. Five concepts were found in existing literature to positively impact client motivation. These concepts were: Social Support, Therapeutic Relationship, Hope, Peer-Mentoring, and Competitive/Game-Based Interventions. The authors illustrated these concepts and provided statements and interventions to allow therapists to explore each concept in order to enhance clients' motivation during SCI recovery. In addition, formalized and well-researched assessments are provided in the product appendices, which provides therapists to analyze the effectiveness of the guide in motivating clients, leading to improved motivation, self-efficacy and functional engagement in activities.

The guide was created with the intent of treating young male clients who have sustained a spinal cord injury. The information in the guide was created through the use of a literature review and one of the author's personal experiences after sustaining a SCI. The guide was developed in order to provide occupational therapists with ideas on how to motivate young male clients with spinal cord injuries, assist clients if they are having difficulties becoming motivated. The guide was not created in order to list the only factors that may motivate clients; rather it was created in order to assist therapists who may be struggling to come up with different ways to motivate their young male clients with spinal cord injuries.

Two models were utilized in the development of this guide. The Model of Human Occupation (MOHO), and the Occupational Adaptation (OA) model. MOHO was relevant to this product because of the importance it places on a client's motivation or *volition* (Kielhofner, 2009). The OA model was important to the development of this guide because it describes the significance of the *adaptation* process a client goes through during the recovery period following an injury (Schkade & Schultz, 2003). Both models are appropriate for this project as they have been developed for occupational therapists' use.

The product, *Motivation: An Occupational Therapist's Guide for Motivating Young Male Clients with Spinal Cord Injuries* can be located in the appendices section of this scholarly project. The guide and other chapters of this scholarly project were developed in the partial fulfillment of the requirements for the Master's of Occupational Therapy degree at the University of North Dakota. References for the entire scholarly project can be located after Chapter V in the references section.

Chapter IV described the general purpose and function of the product created in this scholarly product. Chapter V entails an all-encompassing summary of the scholarly project.

Chapter V

Summary

Chapter V is composed of a summary of this project, the processes of completing this project and an overview of the foreseeable limitations of this project. Further, descriptions of the application of this product have been provided.

The purpose of this project was to explain the role that motivation has in recovery and develop a guide for occupational therapists to address motivation in young male clients following a SCI. The goal for this guide is to assist occupational therapists' attempts to heighten their clients' engagement in occupation and recovery through motivation.

A thorough literature review was conducted to explore the physical and psychological effects of clients who sustained a SCI, the role of motivation in the recovery of clients with SCIs, and theoretical foundation of motivation and occupational engagement. Using available evidence and occupational therapy theoretical models, the authors designed an intervention guide for occupation therapists to use when working with young males with SCIs.

The guide was created according to two occupational therapy theoretical models, the Model of Human Occupation (MOHO) and Occupational Adaptation (OA). The guide encourages the use of three assessments to assess motivation and function related to sustaining a SCI. These assessments include the Functional Independence Measure (FIM®), Volitional Questionnaire (VQ), and General Self-Efficacy Scale (GSE). Based on the theoretical models, the literature review, and assessment implications, five concepts were identified to positively impact client motivation: Social Support; Therapeutic Relationship; Hope; Peer-Mentoring; and

Competitive/Game-Based Interventions. Subsequently, the authors of this guide designed interventions to discover valuable concepts that should be considered in designing interventions and which can be useful in enhancing clients' motivation during SCI recovery.

A limitation of this project includes the limited amount of research in the area of motivational techniques. Despite the described and documented importance of motivation in clients with SCIs, little research has been formally conducted to examine this concept and interventions that can be used to affect motivation in this population. An additional limitation of this project is that this guide is newly created and, subsequently, it has not been tested in order to assess its effectiveness with clients.

The product, *Motivation: An Occupational Therapist's Guide for Motivating Young Male Clients with Spinal Cord Injuries*, is recommended for use in an in-patient rehabilitation center. Possible implementation methods could include having a rehabilitation team meeting to introduce the guide to each of the therapists. Following the meeting, allow for a set time period so that the therapists in the department may become more comfortable with the guide and its concepts. The next step would be to have the occupational therapists practice utilizing some of the concepts, assessments, and methods found in the guide. After having practiced, therapists can utilize the guide with their young male clients who have sustained spinal cord injuries.

Existing evidence has indicated the therapeutic and occupational benefits of addressing motivation. We anticipate that this guide for occupational therapists to address clients' motivation in SCI recovery will increase clients' participation in activities to increase overall quality of life, and improve his functional abilities.

The authors suggest future research in studying the effectiveness of this guide within an in-patient rehabilitation setting. Although this scholarly project focused on the application of motivational concepts for young adult males with spinal cord injuries, the authors believe that these motivational concepts could be used with other populations as well. Further research is suggested to assess the applicability of these motivational concepts with different client populations.

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APPENDICES

Appendix A
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The
Functional
Assessment
Specialists

Uniform Data System

for Medical
Rehabilitation

Telephone
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Fax
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Web site
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Amherst, NY 14228

March 7, 2012

Elizabeth Schleicher
University of North Dakota
Occupational Therapy Department, Hyslop 210
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Enc.
GJF/jlw

Everything you wanted to know about the
General Self-Efficacy Scale but were afraid to ask

by Ralf Schwarzer, May 30, 2011

The purpose of this FAQ is to assist the users of the scales published at the author's web pages

<http://www.ralfschwarzer.de/>

DOWNLOAD of PDFs: http://userpage.fu-berlin.de/~health/self/selfeff_public.htm

Before attending to the questions below you might want to study our web pages. You might not have any questions after reading the web pages.

Do I need permission to use the general perceived self-efficacy (GSE) scale?

You do not need our explicit permission to utilize the scale in your research studies. We hereby grant you permission to use and reproduce the General Self-Efficacy Scale for your study, given that appropriate recognition of the source of the scale is made in the write-up of your study.

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February 28, 2012

University of Illinois at Chicago
Occupational Therapy-CAHS (MC 811)
ATTN: MOHO Clearinghouse
1919 West Taylor Street,
Chicago, Illinois
60612-7250

Michael Nelson, MOTS & Elizabeth Schleicher, MOTS University of North Dakota School of
Medicine and Health Sciences Occupational Therapy Department

Dear Mr. Nelson and Ms. Schleicher:

This letter constitutes permission to reproduce the below excerpt as an addendum to your
Master's Thesis. Please ensure that a full and updated citation is included with the reproduction.

Excerpts:
Volitional Questionnaire Manual

Sincerely,

Renee Taylor, PhD
Director, MOHO Clearinghouse

Appendix B

Motivation: An Occupational Therapist's Guide for Motivating

Young Male Clients with Spinal Cord Injuries



Motivation



An occupational therapist's
guide for motivating young male
clients with spinal cord injuries

University of North Dakota

Occupational Therapy

Michael A. Nelson, MOTS

Elizabeth M. Schleicher, MOTS

Anne M. Haskins, PhD, OTR/L

TABLE OF CONTENTS

Purpose of Guide	2-3
Assessment	5-8
Context/Environment	9-10
Interventions/Resources.....	11-27
Social Support	12-15
Therapeutic Relationship	16-19
Hope.....	20-22
Peer Mentoring.....	23-24
Competitive/Game-Based Interventions.....	25-27
Summary	28
References	50-51
Appendices.....	29-49
<i>Appendix A</i>	29
Functional Independence Measure® Charting Packet.....	30-41
<i>Appendix B</i>	42
Volitional Questionnaire (VQ).....	43-46
<i>Appendix C</i>	47
General Self-Efficacy Scale.....	48-49

A. Purpose of this Guide

Engagement in occupation is vital to a client's well-being. Moreover, humans are occupational beings and the occupations in which they engage in, physically or mentally, shape who they are (Kielhofner, 2009). When physical or psychological disruptions in occupations occur, a client may experience occupational loss (Chan et al., 2000; Craig et al., 2009). As a result, *quality of life* is negatively affected in a client (Wilcock, 1993). In order to fulfill quality of life, motivation should be noted as a determinant to functional outcomes.

Motivation influences engagement in occupation by allowing a client to see opportunities and challenges in his life, what he chooses to do in his life, and how he experiences and makes sense of his occupations (Kielhofner, 2009). After sustaining a SCI, several psychosocial factors of a client are influenced, making the role of motivation an essential component to address in occupational therapy. Therefore, the authors developed this guide to provide occupational therapists with techniques on how to improve motivation in young male clients with spinal cord injury (SCI). The intended population for this guide is young male clients living with SCI. However, this guide can be adapted for females with SCI, if applicable.

Although there may be unlimited techniques/ways to assist in motivating a client with SCI, this guide provides a starting point to design interventions, which enhance client's motivation. The development of this guide was based on both the Model of Human Occupation (MOHO) and Occupational Adaptation (OA). Both of these occupation-based models provide considerations of the person and how he interacts with his environments and engagement in occupations (Forsyth & Kielhofner, 2003; Schkade & Schultz, 2003). Moreover, the use of MOHO in this guideline explores the volitional core of the person, in regards to

developing the occupational profile (see Figure 2) and increasing overall engagement in occupation (Forsyth & Kielhofner, 2003). The use of OA in this guideline provided a foundation for developing resources and interventions that facilitate client adaptation through *relative mastery* (see Figure 3) during the occupational therapy process (Schkade & Schultz, 2003).

The authors of this guideline created an algorithm to depict the occupational therapy process for assessing and addressing motivation in young male clients with SCI (see Figure 1). The authors encourage users of this guide to utilize the following assessments to gather their occupational profile: Functional Independence Measure®, Volitional Questionnaire, and the General Self-Efficacy Scale. Using the factors assessed in the identified instruments, the authors created motivation related concepts, which are categorized and are further explored in this guide. Figures and sections are provided throughout the guide to explore each motivational concept, as they have been researched as ways to increase motivation in clients with SCI. Overall, based on anecdotal research, the authors hypothesize that through the use of this guide, client's functional capabilities and psychosocial statuses will improve and lead to an increased overall quality of life, through engagement in occupations.

Motivation and SCI: The Occupational Therapy Process

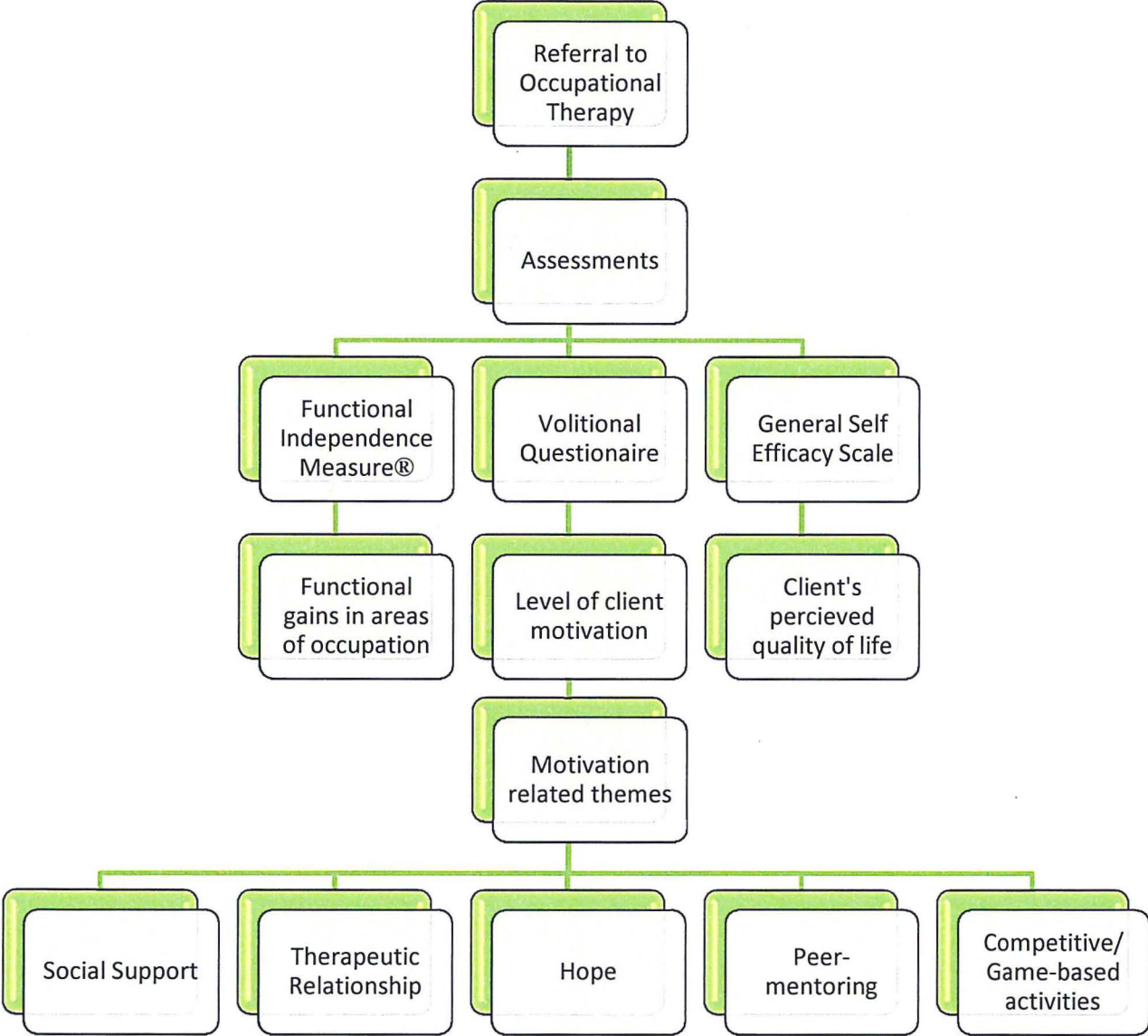


Figure 1

B. Assessment

Within the first two weeks of a client's referral to an in-patient rehabilitation center, therapist should perform three assessments; Functional Independence Measure (FIM®); Volitional Questionnaire (VQ); and General Self Efficacy Scale (GSE). The FIM® will provide the therapist with the client's areas of occupational functioning weaknesses (Uniform Data System for Medical Rehabilitation, 1999). The VQ will provide the occupational therapist with the client's current level of motivation (Kielhofner, 2009). Meanwhile, the GSE examines the client's belief in his abilities (Schwarzer & Jerusalem, 1995). FIM® scores will provide the therapist with areas to address for therapy sessions. Meanwhile, the VQ scores show if the client is lacking motivation and, therefore, limiting his participation in therapy sessions. Lastly, the GSE score will assist the therapist in understanding how the client feels regarding his current abilities (Schwarzer & Jerusalem, 1995). Through addressing the motivational concepts (which were identified through a thorough review of literature) of Social Support, Therapeutic Relationship, Hope, Peer-Mentoring, and Competitive/Game-Based Interventions, it is thought the client's motivation and self-efficacy will improve, thereby improving his engagement in therapy interventions. In return, by improving the client's engagement in therapy interventions, his FIM® (i.e. function) scores will also improve.

To gather information about your client, the following Figure 2 depicts concepts derived from the Model of Human Occupation (MOHO) (Forsyth & Kielhofner, 2003). Figure 2 encompasses the client's *Volition, Habituation, and Performance Capacity* (Kielhofner, 2009). By addressing these areas, the occupational therapy process will be client-centered.

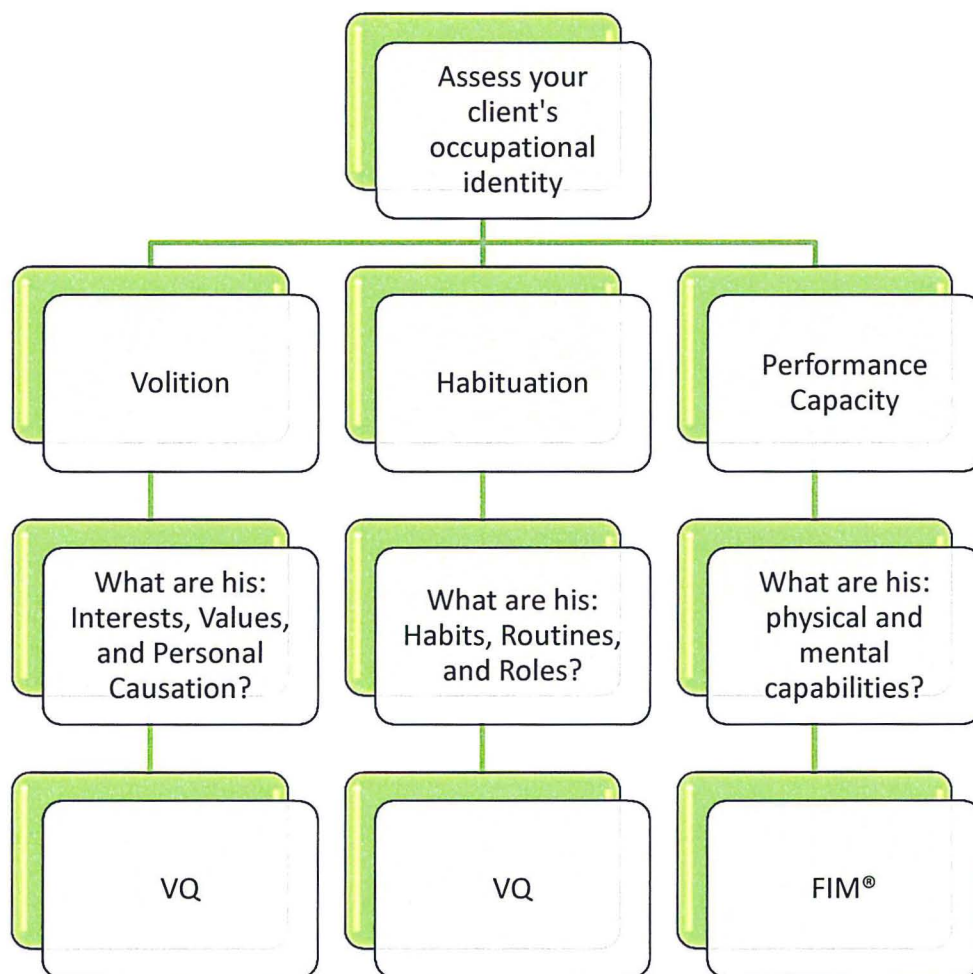


Figure 2

To further build on the occupational profile, help empower your client to set realistic and meaningful goals. Create “just the right challenge” by considering his *relative mastery* as a response to his occupational challenge, physically or psychologically (Schkade & Schultz, 2003).

Figure 3 depicts how to do this.

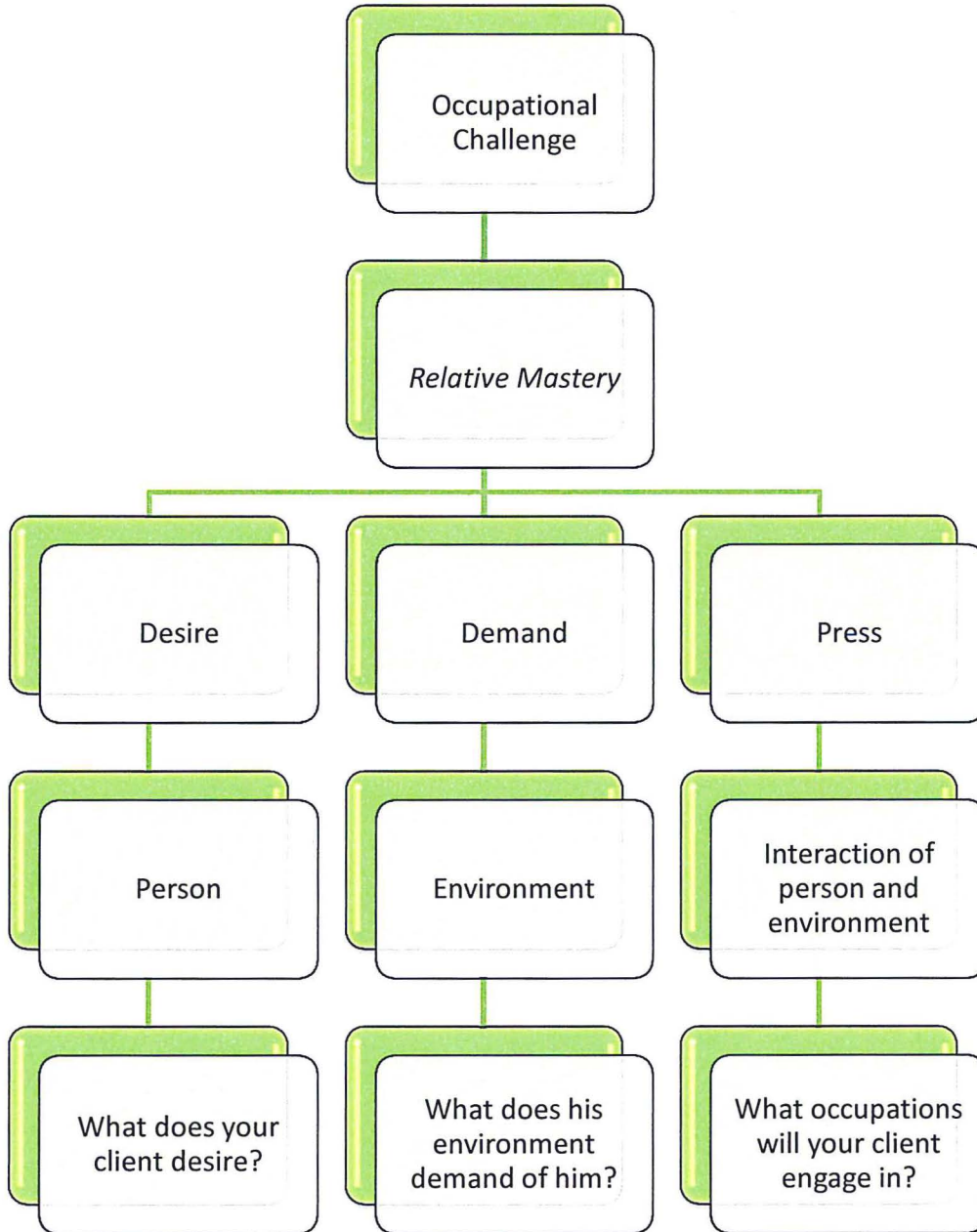


Figure 3

As addressed in the aforementioned occupation-based models, this guideline incorporates and addresses the person, environment, and his occupations. By addressing the central concept of motivation, this guideline should be noted as a determinant to functional outcomes. It will explore motivation through the client and his environment in order to increase occupational engagement and overall quality of life.

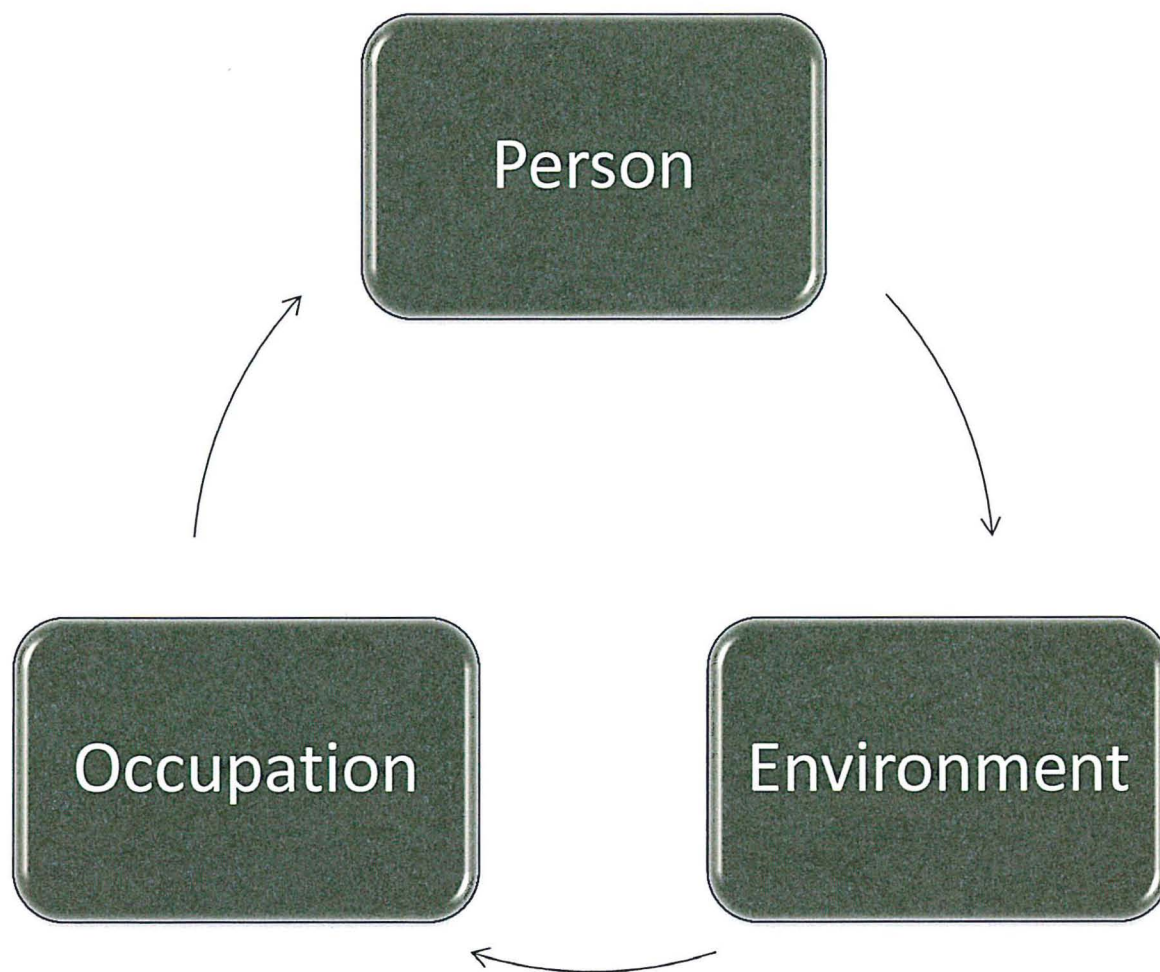


Figure 4

C. Context/Environment

Client's context and/or environment are important concepts in the recovery following a spinal cord injury. Interventions and other interactions with a client take place in several different contexts and it is vital for occupational therapists to provide therapy in an environment that is as "like" the client's environment as possible. Each motivational concept located in this therapy guide interacts with the client's environment in some way.

- *Cultural:* When interacting with a client and attempting to instill hope, Occupational Therapists address client's beliefs regarding his injury, dealing with his culture.
- *Personal:* As the Occupational Therapist interacts with a client, he/she take the client's gender and age into account, as this guide is created for young male adults. Client's personal interests and values are also crucial when creating personalized interventions.
- *Temporal:* The temporal context is addressed with this guide by Occupational Therapist's taking into account how long the client has been in therapy, or through examining with the client how far he may have come during this time at the rehab.
- *Virtual:* A client's virtual environment may be addressed through the use of an online peer-mentoring program. This can be achieved through the use of gaming and other computerized interventions demonstrated in the guide.
- *Physical:* Through the use of adapting the environment to provide a natural environment for the client, therapists address the physical environment during the rehabilitation process. (e.g. providing interventions in a natural setting: bathroom, kitchen, bedroom, etc.)

- *Social:* The social environment is addressed throughout this guide in several ways. The guide encourages the client to engage in social activities to improve his support systems. The interaction between the therapist and client are also important for the client's social environment.

Information formulated from the American Occupational Therapy Association: Domain and Process (2nd Ed.), 2008.

D. Interventions/Resources

The following pages of this guide provide motivational interviewing questions, interventions, and resources to utilize. The sections are divided up into the main concepts that literature has showed to increase client motivation: Social Support, Therapeutic Relationship, Hope, Peer-Mentoring, and Competitive/Game-Based Interventions.

How is your client responding?

- Is he stuck as if he hit a roadblock?
 - Primitive Response
 - Provide “Just the right challenge” for client to experience small successes.
- Is he hyperactive at wanting to work in therapy?
 - Transitional Response
 - Implement structure with goals and interventions, to keep client focused.
- Is he balanced and goal directed?
 - Mature Response
 - Ideal for progress. Encourage goal-directed behavior.

Social Support

Address social support if a client scored low on the GSE and demonstrates isolative tendencies, avoids meeting with others or talking about injury with his friends and/or family.

1. Ask the client questions regarding his view about his family/friend support.
 - a. “Why is it important to you to have support from your family/friends during this time?”
 - b. Have you discussed with your family some of the difficulties you are going through?”
 - If yes, how did it go?
 - If no, why not?
 - c. “Tell me about the communication going on with your family/friends; do you get to talk often?”
 - d. “Do you get to see your family/friends enough? If not, what do you think could be done to improve the situation?”
 - e. “How would you feel about having someone from your family come to a therapy session?”
 - “Tell me how you feel it would be helpful?”
 - f. “Next time we have a public outing, how would you like to ask a friend/family member to come along?”
 - g. “How much social support will you have when you are discharged from the hospital?”

- h. “What is your home environment like? Do you have, or would you like, a support system?”
 - i. “Tell me about any concerns you have regarding finding a social support system when you leave?”
- 2. Statements that may be made to client or family/friends to promote engagement in social support activities.
 - a. “It is important that you stay connected with friends/family. Tell me about how you are doing with this.”
 - b. “It is important for your friends/family to observe what we do in therapy, if you’re comfortable with it, we should invite them to a therapy session.”
 - c. “It is important that you support your loved one during his time of need, as it will be beneficial to his recovery.”
- 3. Interventions/Activities that can be utilized that encourage social support.
 - a. Perform interventions within an area that is not isolated, promoting interactions with others. Interventions may be performed in the therapy gym, or perhaps a meal intervention in the cafeteria; anywhere among people.
 - i. Remember: It is important to have the client stop isolative tendencies and encourage social activities.
 - b. Set-up a therapy session with the client’s family or friends, encourage discussion between the two regarding the therapy process.

- i. Teach family members about any assistive technology the client uses, and have the client demonstrate (i.e. sock-aid, reacher, wheelchair devices, adapted utensils).
 - ii. Encourage client to describe what he does in therapy, demonstrating different interventions he performs with the occupational therapist.
 - iii. Educate members of the client's support system on some therapy activities they may perform with the client after his sessions (i.e. stretches, range of motion, etc.).
 - iv. Leave time at the end of session to answer questions from family and assist in guiding discussion between client and members of the client's support systems.
- c. Schedule a client outing with his family/friends.
- i. Take client and his support system on a public outing in the community (preferably somewhere he has been before).
 - ii. Rather than the therapist assisting the client, have members of the clients support system assist client whenever there is a difficult situation.
 - 1. This will promote discussion and confidence in both the client and his members of his support system when he transfers out of the hospital.
4. Provide client and members of his support system with resources.

- a. Provide literature, videos, or credible website with information for the client and family to learn more about SCI recovery. It is important for the client and family to be educated regarding the injury, in order to promote discussion regarding the process.

www.christopherreeve.org

[http://www.mayoclinic.com/health/spinal-cord-](http://www.mayoclinic.com/health/spinal-cord-injury/DS00460/DSECTION=coping-and-support)

[injury/DS00460/DSECTION=coping-and-support](http://www.mayoclinic.com/health/spinal-cord-injury/DS00460/DSECTION=coping-and-support))

- b. If you believe that there are complicated social support dynamics, which are interfering with the client's recovery, refer client to social worker, or psychiatrist in order to provide the best care possible.

Therapeutic Relationship

When there are problems regarding the interaction between the client and the therapist, or client compliance regarding interventions, the therapist should work on building the therapeutic relationship. The therapeutic relationship can be enhanced in a variety of ways; incorporation and utilization of therapeutic modes being one way (Taylor, 2008).

Advocating: Ensure opportunities for access to needed materials and participation in valued occupations.

1. Ask questions promoting rapport with the client.

Collaborating: Make decisions with your client, provide feedback, empower, and encourage independence by letting client take the lead in interventions.

- a. "Tell me about areas of your life that are important to you."
- b. "What kinds of goals would you like to make for yourself?"
 - i. "What is it that makes these goals important to you?"
 - ii. "How do you think making these goals may motivate you?"
- c. "How can I help you through this process?"
- d. "What would you picture our sessions to be like? How do we interact?"
- e. "What times are better for you for therapy?"
- f. "Are there things you would enjoy doing at the start of therapy? At the end?"

2. Empathize with the client.

- a. Let the client know that you notice how difficult this struggle is for him and that that you are there to help him.
- b. Acknowledge the difficulties the client may be experiencing and validate his feelings.

- i. Ex. “I have noticed how difficult it is for you to be unable to perform this task as you once did. That must have been hard.”
3. Promote engagement in challenging tasks, pushing the client for increased participation in activities.
 - a. Ex. A client may be nervous to attempt a certain task such as a sliding board transfer, for fear of failure. It is important that the therapist utilize his/her relationship with the client to promote engagement in challenging activities to improve the client’s functional outcomes.
 - b. Utilize positive affirmations and challenging statements to encourage the client’s participation in the activity.
 - i. “If we do not try, how will we know if you can or can’t do it?”
 - ii. “I understand that you are nervous, but it is important that we try so that we can measure where we are in your recovery and improve.”
 - iii. “Although you don’t think you can do it, I would like you to try. You may surprise yourself.”
 - iv. “In order to improve, it is important to attempt different tasks even if they are or appear difficult.”
 - v. “I will be here to support you through every step.”

Instructing:
Emphasize educational aspects of therapy, structure the information you share, and provide rationale.

Problem-Solving:
Reason with your client by asking questions and exploring benefits and barriers to each situation.

- vi. “It is important to believe in yourself, and try each task to the best of your ability.”
- c. By encouraging and going through the challenging tasks with the client, the therapist is continuing to strengthen the therapeutic relationship.
 - i. Difficult transfers.
 - ii. Attempting challenging balance activities.
 - iii. Attempting to perform standing activities with client who has paresis SCI.
 - iv. Initial showering activities.
- 4. Advocate for client’s rights.
 - a. Ensure that client receives appropriate equipment.
 - i. Appropriate bed.
 - ii. Correct wheelchair based on the type of injury.
 - iii. Proper wheelchair cushion.
 - iv. Any adaptive equipment (utensils, reacher, sock-aid, etc.).
 - b. Ask client if he believes his needs are being met.
 - i. “Is there anything you feel you are not getting here that you should, if so what are they?”
 - ii. “Do you feel comfortable with the staff? How do you think things are going here with everyone?”

Encouraging: Instill your client with hope and courage, positive reinforcement, cheering, compliments, and motivational words.

iii. “Is there anything I can do to help you get your needs met?”

5. Educate client regarding his injury.
 - a. Inform client on type of injury he has sustained.
 - b. Provide information regarding common recovery patterns.
 - c. Discuss specific information regarding the client’s specific information.
 - d. Provide resources for client to look at himself in his own time.

Empathizing: Strive to understand your client’s perspective and validate their emotions.

Hope

Address hope if the client is appearing depressed, expressing disappointment with capabilities and lack of return after injury.

1. Provide positive affirmations promoting positive thoughts regarding recovery.
 - a. “Although the spinal cord injury recovery process varies, it is helpful to maintain a positive attitude.”
 - b. “I may not know how much function may return, but assuming the worst will not help the recovery process.”
 - c. “There are plenty of success stories regarding people regaining lots of function after suffering a spinal cord injury.”
 - i. Provide patient with resources (i.e. newspaper clippings, news shows, websites such as www.christopherreeve.org).
 - d. “In order to improve, it is important that you engage in therapy sessions and hope that things can get better in order to achieve the best results possible.”
2. Incorporate graded interventions in therapy sessions providing “just right challenge”.
 - a. Begin interventions with activities that the client can easily achieve, improving his self-efficacy and belief in his abilities.

“Just Right Challenge”

Once your client has experienced small successes, grade interventions to more difficult levels and ask challenging questions.

- i. Ex. Hand strengthening activity
 1. Have client begin with the simple activity of opening and closing his hands for an extended period of time, seeking a certain number of closures.
 2. As client succeeds in activity, add an item the client should grasp each time, working on successfully holding and letting go of the item.
 3. Challenge the client further by having him move the item after grasping it, then letting the item go.
 4. Begin using different items and weights, continually increasing the challenge to the client.
3. Provide videos, clips, and music of people overcoming obstacles.
 - a. News clips of real people overcoming their injuries.
 - b. Motivational movies of individuals adapting and achieving goals (i.e. Rocky, Remember the Titans, 8 mile, etc.). Each movie should be age appropriate and consistent with the client's interests and values.
 - c. Encourage the client to listen to motivating music before and after therapy sessions. If applicable and safe, allow client to listen to motivating music during therapy session.
4. Have the client create an interest checklist or things he would like to participate in after therapy.
 - a. In having the client write down his interests, he will be more apt to want to engage in activities, which will help him in attaining his goals.

- b. The client's hope will improve as he has a goal, which he desires to engage in.
 - i. Ex. The client indicates that he would like to go fishing.
 - 1. Discuss with client about his desire to fish.
 - 2. Ask the client how important this is to him.
 - 3. Talk about the areas and things he will want to work on in order to engage in this occupation.
5. Remind the client of progress that has been made.
- a. It is important to remind client of how much improvement he has made during his therapy.
 - i. Show the client previous scores on assessments and how he has improved.
 - b. Explain to client that it is important to continue to look for more improvements.

Peer-Mentoring

To be used if client reports not understanding his injury, not having anyone to talk to about what it is like to have the injury, expresses desire to talk with someone else who has gone through this.

1. Statements promoting engagement with a peer-mentor.
 - a. “I know of someone who has had a similar injury as yours. He said it helped to talk with someone who had gone through this before.”
 - b. “Clients often tell me that they wished they could talk to someone else who had a spinal cord injury.”
 - c. “Discussing these problems with someone else who has gone through them may help you understand things better.”
2. Statements enabling interaction with a peer-mentor.
 - a. “I know of some people who have gone through a situation similar to yours. Would you be interested in talking with them?”
 - b. “Although everyone’s recovery is different, I think talking with others who have gone through similar situations would be beneficial. Would you like me to get you in contact with them?”
 - c. “If you are interested, I could contact some support groups of people who have gone through the recovery process of a spinal cord injury.”
3. Set up face to face or Skype peer-mentoring session.
 - a. Contact individual who has sustained a similar SCI and inquire about his interest in interacting with an individual who is currently recovering from his/her SCI.

- b. Provide the client with contact information from a peer-mentor and encourage client to meet with peer-mentor.
 - c. If either client or peer-mentor is nervous about meeting, offer to facilitate initial meeting.
 - d. If there are no peer-mentors in the treatment region, attempt to create a “Skype” meeting between two individuals.
4. Promote positive thinking when meeting with peer-mentor.
- a. Ideas to be encouraged:
 - i. If he can do it, so can I.
 - ii. I want to be where he is in my recovery.
 - iii. Seeing my peer-mentor do so well motivates me to want to do more.
5. Encourage client to become peer-mentor himself after leaving hospital.
- a. Motivate client to complete therapy activities to the best of his abilities and suggest that he may become a peer mentor one day.
 - b. Promote the thinking that the client wants to be an inspiration to others, thereby improving his engagement in therapy.

Competitive/Game-based Activities

To be used if client is having difficulties sustaining attention during interventions and demonstrates a lack of interest in therapy sessions.

1. Ask questions regarding possible competitive or interesting game activities the client would be interested in participating in.
 - a. “Do you believe that engagement in games would be interesting and motivating? If so, how do you think they could be useful in your recovery?”
 - b. “What types of games or competitive activities do you enjoy doing?”
 - c. “Do you find participating in competitive games would be motivating? How so?”
2. Possible competitive interventions to perform to promote engaged participation and increased effort with therapy.
 - a. Wii gaming system
 - i. Have client choose a game of interest to him.
 - ii. Create goals on games to meet in order to encourage the client to excel.
 - iii. Work on balance, fine motor activities, coordination, speed, and activity tolerance.
 - b. X-Box Kinect
 - i. Have client choose a game of interest to him.
 - ii. Create goals on games to meet in order to encourage the client to excel.

- iii. Work on balance, fine motor activities, coordination, speed, and activity tolerance.
- c. PlayStation 3 Move
 - i. Have client choose a game of interest to him.
 - ii. Create goals on games to meet in order to encourage the client to excel.
 - iii. Work on balance, fine motor activities, coordination, speed, and activity tolerance.
- d. Dynavision
 - i. Create goals to achieve with client regarding specific number to reach.
 - ii. Work on clients balance, coordination, speed, and activity tolerance.
 - iii. Challenge client to improve his score on each attempt.
- e. Baltimore Therapeutic Equipment (BTE)
 - i. Select specific tasks with client to complete on BTE.
 - ii. Have client create goals to meet while engaging in BTE task.
 - iii. Encourage client to beat his previous score each time he engages in the task.
- f. Creative competitive activities
 - i. Identify areas of interest with client.
 - ii. With client, create game or competitive activity working on underlying performance skills.

iii. Continue to perform activity, challenging client to improve each time he engages in the activity, and promote improved performance.

3. Music

- a. Ask client whether he enjoys listening to music while engaging in activities.
- b. Have client choose songs which he finds motivating to listen to.
- c. If appropriate, have client listen to music while engaging in activities if it can assist with functional performance.

E. Summary

Overall, *motivation* influences engagement in occupation by allowing a client to see opportunities and challenges in his life, what he chooses to do in his life, and how he experiences and makes sense of his occupations (Kielhofner, 2009). Through the use of the concepts found in this guide, occupational therapists will be able to assist in improving client overall motivation and quality of life.

“A hero is an ordinary individual who finds the strength to persevere and endure in spite of overwhelming odds.”

~ Christopher Reeve

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Guide Appendix A

The Functional Independence Measure (FIM®) Charting Packet. (see following pages)

FIM

Charting

Packet

Your Comprehensive Guide to FIM
Scoring
(also included Motor FIM Step Table and
Communication/Social Cognition
FIM Percentage Guide)

FIM Charting

FIM Levels

No helper

Independent – complete independence (timely, safely, no adoptive equipment or assistive device)

Modified independent – (device, safety, extra time)

Helper

SBA – cueing, coaxing, set-up

MIA – pt. does at least 75% of the task, if you touch the pt. in any way, they are at least MIA

MOA – pt. does 50-74% of the task

MAA – pt. does 25-49% of the task

Total – pt. does less than 25% of the task

General tips

-If the family helps a pt. with ADLs or mobility, ask the family what they helped the pt. with and chart it with a comment “per family report”.

-If something was not done, chart “not performed”. If a pt. refuses, chart “refused”. There should be something charted in the ADLs/transfers section every shift.

-Being in the room and watching the pt. do something does not automatically make the pt. SBA. If you feel the pt. would be safe to do the tasks without you being in the room, then you can chart modified independent or independent.

-If the pt. independently completes the task in 3 times the normal amt. of time it should take, they are modified independent.

-Deficit is what YOU did for the pt.

-If you need 2 people to complete the tasks they are automatically total assist. This includes when one staff holds the w/c while the other assists the pt. You can chart this 2 ways: total and specify in comments MOA2 or select MOA and select assist of 2.

-If you use a mechanical device for transfers, they are total.

Communication/Cognitive

-All areas need to be done every shift including nights. If the FIM score is less than independent, you need to comment why (cues, reminders, impulsive, agitation, etc.).

-Don't be surprised if your scores differ from therapy. This will not be unusual for pts. needing cues or more.

-Scores are based on the burden of care, so even if the pt. needs a sitter during the day, they could be Independent at night if they are not trying to get out of bed and don't go to the BR.

-Base your scores on how much time someone from nursing (nurse, CNA, sitter) actually interacted with the pt. AND the pt. needed assistance

Modified independent – has only mild difficulty AND self corrects, needs extra time (3 times normal) or needs assistive device

Nursing (based on an 8 hr. shift): <1 hr./shift = SBA 1-2 hrs./shift = MIA 2-4 hrs./shift = MOA
4-6 hrs./shift = MAA >6 hrs./shift = total

OT/PT (based on 1.5hrs./day): <10 min./day = SBA 10-20 min./day = MIA 20-45 min./day =
MOA 45 min. – 1 hr./day = MAA >1hr./day = total

ST/Rec (based on ½ hr./day): <3 min./day = SBA 3-8 min./day = MIA 8-15 min./day = MOA
15-23 min./day = MAA >23 min./day = total

Comprehension – understands complex directions/conversation

select auditory OR visual – specify type (writing, sign language, gestures if aphasia, deaf, or hard of hearing) AND give a FIM score

Glasses are only considered an assistive device if they comprehend visually

Modified Independent – assistive device, mild difficulty, self corrects, and/or needs extra time. If pt. has a hearing aide, they are at least modified independent

SBA – occasional prompts, cues, supervision, encouragement <10% of the time

MIA – requires prompts, cues, supervision, encouragement for basic needs 11-25% of the time

MOA - requires prompts, cues, supervision, encouragement for basic needs 26-50% of the time

MAA- uses only simple words or common expressions/gestures

Total – doesn't understand simple spoken expressions/gestures, doesn't respond appropriately/consistently despite prompting

Expression – clear expression of complex language/ideas

select verbal OR non-verbal (specify type: writing, communication device) AND give a FIM score

Modified Independent – assistive device, mild difficulty, self corrects, and/or needs extra time

SBA – occasional prompts, cues, supervision, encouragement <10% of the time

MIA – requires prompts, cues, supervision, encouragement for expressing basic needs 11-25% of the time

MOA - requires prompts, cues, supervision, encouragement for expressing basic needs 26-50% of the time

MAA – expresses only single words or common expressions/gestures

Total – doesn't express basic needs appropriately/consistently despite prompting

Social interaction – interacts appropriately with staff, other pts., family members

Modified Independent – assistive device, mild difficulty, self corrects, and/or needs extra time. If pt. is on a med. for mood and/or behavior control (anti-depressant, etc.), they are at least modified independent

SBA – occasionally requires monitoring, verbal control, cues, encouragement only under stressful/unfamiliar conditions but <10% of the time

MIA – requires prompts, cues, supervision, encouragement to interact appropriately 11-25% of the time

MOA - requires prompts, cues, supervision, encouragement to interact 26-50% of the time

MAA - requires prompts, cues, supervision, encouragement to interact appropriately 51-75% of the time, may need restraint due to socially inappropriate behaviors

Total - requires prompts, cues, supervision, encouragement to interact appropriately >75% of the time, may need restraint due to socially inappropriate behaviors

Problem solving – recognizes complex problems, makes appropriate decisions, adjusts to changes, carries out steps, evaluates the solution

Modified Independent – assistive device, mild difficulty, self corrects, and/or needs extra time

SBA – occasionally requires cues/prompts to solve problems only under stressful/unfamiliar conditions <10% of the time

MIA – requires prompts, cues, supervision, encouragement to solve routine problems 11-25% of the time

MOA - requires prompts, cues, supervision, encouragement to solve routine 26-50% of the time

MAA - requires prompts, cues, supervision, encouragement to solve routine problems 51-75% of the time

Total - requires prompts, cues, supervision, encouragement to solve routine problems >75% of the time; may require 1:1 companion (sitter)

Memory – recognizes people, remembers routines, executes requests without reminders
· May use self-initiated or environmental prompts/cues independently

Modified Independent – assistive device, mild difficulty, self corrects, and/or needs extra time

SBA – occasionally requires cues/prompts to remember only under stressful/unfamiliar conditions <10% of the time

MIA – requires prompts, cues, supervision, encouragement to remember 11-25% of the time

MOA - requires prompts, cues, supervision, encouragement to remember 26-50% of the time

MAA - requires prompts, cues, supervision, encouragement to remember 51-75% of the time

Total - requires prompts, cues, supervision, encouragement to remember >75% of the time

Bowel/Bladder

-Try your best to determine if the pt. is using an assistive device (brief, pull-up, or liner) for bladder or bowel incontinence and only chart the assistive device under that area

-If the pt. is not wearing an assistive device and they are not on any meds, they are independent

-If the pt. is modified SBA or lower, chart why in the comments (i.e. cues, how much help they need with the device, etc.)

- An accident is defined as the act of soiling linen or clothing with urine or stool. It includes bedpan and urinal spills as well as colostomy and foley leakage. If the urine or stool is contained in a device (pull-up, liner, etc.), it is an incontinence, not an accident.

-If the pt. is wearing a pull-up as underwear, please note that in comments. They should be encouraged to wear regular underwear.

- If a pt. is wearing a pull-up or attends, determine the # of steps needed to complete the task and then figure out what percentage each task is worth. This will determine the level of assistance they need to manage the device.

Changing Pull-up: pull down to feet, doff left foot, doff right foot, donn left foot, donn right foot, pull over hips. Each task is worth 17%.

Changing Brief: loosen left side, loosen right side, remove brief, position new brief, secure left side, secure right side. Each task is worth 17%.

If the pt. is incontinent, then adding cleaning up self would make each task worth 14%.

Changing liner: pull pants down, remove liner, place new liner, pull pants up. Each task is worth 25%.

If the pt. is incontinent, then adding cleaning up self would make each task worth 20%.

If the pt. is not changing the pull-up, brief or liner, then there would be just 2 tasks (up and down) each worth 50%

-A timed void program is not an assistive device. An accurate rating for this is determined by the % of the time the pt. remembers to go to the BR to prevent an accident. So if the pt. is on a q4h voiding program and they only remember to ask to go to the BR 25% of the time and the staff has to remind them the rest of the time, they would be MAA for bladder management.

Bowel management – this includes complete and intentional control of the bowel and necessary use of equipment or agents for bowel control. This does NOT include how they got to the toilet or pulling pants and underwear up, down, and wiping. It does involve changing a liner, pull-up, brief, or ostomy or managing a bedpan/commode.

Bowel accident – soiling of linen, clothing, and/or the floor.

Independent – Pt. controls the bowel completely and intentionally and has no accidents. No equipment or agents are required.

Modified independent – pt. takes a med. for bowels (colace, senna, miralax, etc. does not include anti-diarrheals or natural products such as prunes, fiber cereal, etc.)

Pt. has an ostomy that they manage completely by themselves including changing and emptying into the toilet (most of our pt's with ostomies will be total).

Pt. obtains, positions, and uses a commode or bedpan and they empty the bucket into the toilet themselves.

Pt. uses an assistive device (brief, pull-up, or liner) and they manage it and any incontinence by themselves.

Pt. inserts suppository themselves.

Pt. requires more than a reasonable amt. of time.

SBA – pt. uses a commode and staff or family empties it into the toilet

Staff places the bedpan within reach, empties it or both, but the pt. positions and removes it.

Pt. needs SBA (cues, reminders) for safety to use commode, or manage a device and/or clean up incontinence, BUT you are not touching them.

Pt. needs cues to insert the suppository themselves.

MIA – Pt. needs steadying or very minor help to use commode or bedpan, or manage a device, and/or clean up incontinence.

Helper lubricates and inserts suppository, provides digital stimulation, or lubricates and inserts an enema.

Staff positions the bedpan.

MOA – pt. is doing 50-74% % of the task. Staff positions bedpan and holds it in place.

MAA – pt. is doing 25-49% of the task. Staff positions the bedpan, holds it in place, and assists the pt. in rolling on OR off.

Total - pt. is doing less than 25% of the task. Pt. needs manual extraction.

Staff positions the bedpan, holds it in place, and assists the pt. in rolling on AND off.

Staff positions the pt., places a pad, lubricates and inserts the suppository and provides digital stimulation.

Staff changes the device and cleans the pt. after an accident or incontinence.

2 staff are needed.

Bladder management – the complete and intentional control of the bladder and necessary use of equipment or agents for bladder control. This does NOT include how they got to the toilet or pulling pants and underwear up, down, and wiping. It does involve changing a liner, pull-up, or brief or managing a catheter or urinal/commode/bedpan. A dialysis pt. who doesn't void is independent, not total because dialysis has nothing to do with control of the bladder.

Bladder accident - soiling of linen, clothing, and/or the floor.

Independent – Pt. controls the bladder completely and intentionally and is never incontinent. No equipment or agents are required.

Modified independent – pt. takes a med. for bladder (detrol, urecholine, flomax etc.)

Pt. has an ostomy or foley that they manage completely by themselves including changing and emptying into the toilet (most of our pt's with ostomies and foleys will be total)

Pt. uses obtains, positions, and uses a urinal, bedpan, or commode and empties it in the toilet themselves

Pt. uses an assistive device (brief, pull-up, or liner) and they manage it and any incontinence by themselves.

Pt. gathers equipment, performs the self-catheterization, independently and empties the urine.

Pt. requires more than a reasonable amt. of time.

SBA – pt. uses a urinal, bedpan, or commode that is within reach and staff or family empties it into the toilet

Pt. needs SBA (cues, reminders) for safety to use urinal, commode, or manage a device and/or clean up incontinence, BUT you are not touching them.

Pt. need set up of the catheterization equipment and/or supervision of the pt. while pt. performs the catheterization.

MIA -- Pt. needs steadying or very minor help to use urinal, commode, or manage a device, and/or clean up incontinence.

Staff positions the urinal/bedpan.

MOA -- pt. is doing 50-74% % of the task. Staff positions bedpan and holds it in place.

MAA -- pt. is doing 25-49% of the task. Staff positions urinal, holds it in place, removes it and empties it.

Staff positions the bedpan, holds it in place, and assists the pt. in rolling on OR off.

Total - pt. is doing less than 25% of the task. Staff positions the bedpan, holds it in place, and assists the pt. in rolling on AND off.

Staff performs the entire catheterization procedure or pt. has a foley or supracubic cathether or urostomy that staff does all the cares for.

Staff changes the device and cleans the pt. after an accident or incontinence.

2 staff are needed.

ADLs

There is a graph at the back of this packet (Motor FIM step table) that you can use to determine the % of the task a pt. completed when there are multiple steps. You plug in the steps completed by the pt. and the total # of steps in the activity.

Eating -- Using suitable utensils to bring food to the mouth, chew the food, and swallow it once presented in a customary manner (includes nutrition and hydration). Consider the following when giving a FIM score: picking up a utensil, scooping food, bringing hand to mouth, chewing/swallowing and drinking from a cup.

NOTE: The fact that the pt. is eating in the dining room and has their tray brought to them does not make them SBA. It needs to be assessed if the pt. actually needs help opening containers, cutting meats, etc. or if it is just being done as a courtesy.

Modified independent -- food consistency that is alternated from normal (pureed, mechanical soft, cut-up meats, thickened liquids)

Pt. has dentures that they insert themselves

Pt. uses an assistive device independently such as a rocking knife, built up silverware, etc.

Pt. requires more than a reasonable amt. of time.

SBA -- helper applies an orthoses, opens containers, cuts meat, butters bread, pours liquids, or inserts pt's dentures

Pt. needs cues, reminders to eat/swallow safely.

MIA -- occasionally needs help to scoop food OR occasionally help bring food to the mouth

Staff checks for pocketed food

MOA -- staff scoops every bite of food, pt. brings food to mouth

MAA -- staff provides hand-over-hand assistance to scoop each bite and bring each bite of food to the mouth

If pt. is able to chew and swallow food and drink from a cup, but the pt. requires a helper to complete all other eating tasks

Total -- pt. relies on staff to administer parenteral or gastrostomy feedings or IV fluids for hydration.

If the pt. is eating and they have parenteral or gastrostomy feedings or IV fluids for hydration, they are still considered total.

Grooming -- includes oral care, hair combing/brushing, wash/rinse/dry hands and face and may include shaving and applying make-up. Also includes obtaining articles necessary for grooming.

For most females, grooming includes 4 tasks, so each task = 25%. Men will have 5 tasks if they shave and then each task is worth 20%. It does not include how the pt. got to the sink or whether the pt. completes the task sitting or standing. NOTE: in our rehab setting, the sink area should be set up the way it would be at home (towels, hygiene products available, etc.). If you have to restock the area, that doesn't make them SBA. If you have to actually hand the pt. items because they can't get them for themselves from the sink area, that would be SBA.

Modified independent – pt. uses an assistive device independently such as denture suction brush or long-handled comb/brush

Pt. stands at the sink with an assistive device (walker, etc.).

Pt. requires more than a reasonable amt. of time.

SBA – staff applies the assistive device, sets out equipment (toothbrush, towel, etc.), provides initial prep (such as applying toothpaste, opening containers, handing pt. equipment).

NOTE – everything should be in the BR as the pt. would have it at home (i.e. linen, toothbrush, comb, etc. are reachable). Bringing the pt. a towel or toothpaste does not make them SBA. It should already be on the towel bar or at the sink.

MIA – pt. needs steadying to complete tasks

MOA – pt. performs 2 of the 4 tasks or 3 of the 5 tasks

MAA – staff provides hand-over-hand assistance

Pt. performs 2 of the 5 tasks.

Total – staff provides 75% or more help with grooming.

Pt. performs 1 of the 4 tasks.

Bathing – includes washing, rinsing, and drying the body from the neck down (excluding the neck, back, and hair) in either a tub, shower, or sponge/bedbath

There are 10 body parts and each is worth 10%

Chest	Buttocks
Left arm	Left upper leg
Right arm	Right upper leg
Abdomen	Left lower leg, including foot
Perineal area	Right lower leg, including foot

Modified independent – pt. needs an assistive device such as a shower chair, grab bar, long handled sponge, hand-held shower head, or takes extra time

SBA – staff gathers bathing supplies, applies assistive/adaptive devices, lathers washcloth, hands the pt. equipment, adjusts water temperature

Pt. needs cues or SBA for safety

MIA – Pt. washes 8 or more body parts or just needs steadying

MOA – Pt. washes 5-7 body parts

MAA – Pt. washes 3-4 body parts or pt. requires hand-over-hand assistance to complete bathing.

Total – Pt. washes 2 or less body parts

Upper body dressing – includes dressing and undressing above the waist, as well as applying/removing a prosthesis or orthosis.

Determine the # of steps needed to complete the task, not the # of articles of clothing.

Bra – left arm in, right arm in, hook (3 steps). Could be 4 steps if pt. has to hook the bra in front and turn it to the back. PLUS shirt - left arm in, right arm in, around the back OR over the head, pull down in back OR button/zip (4 steps). So there is a total of 7- 8 tasks and each task = approx. 12-14%

For a male, there would only be 4 tasks, so each task = 25%.

Modified Independent – pt. uses a device such as a dressing stick, reacher, long handled shoe horn, sock aid, button hook, velcro fasteners that are alterations to the normal clothing

Pt. uses a walker or other assistive device to obtain clothing

Pt. requires more than a reasonable amt. of time.
SBA – pt. needs SBA for safety, cues, or coaxing.
Pt. needs help obtaining clothing, applying prosthesis, setting out dressing equipment.
MIA – pt. requires steadying assist and/or completes 75-100% of tasks.
Pt. needs only incidental help such as buttons, zippers, snaps.
MOA – pt. completes 50-74% of the task
MAA – pt. completes 25-49% of the task
Total – Pt. completes <25% of the task. The pt. requires assistance from 2 staff to dress.

Lower body dressing - includes dressing and undressing below the waist, as well as applying/removing a prosthesis.

Determine the # of steps needed to complete the task, not the # of articles of clothing.

Then figure out what percentage each task is worth.

Underwear – left leg in, right leg in, pull up (3 steps)

Elastic pants - left leg in, right leg in, pull up (3 steps)

Zipper pants - left leg in, right leg in, pull up, zip up (4 steps)

Belt – thread and buckle (2 steps)

Socks left leg on, right leg on (2 steps)

Shoes - left foot on, right foot on, fasten/tie (3 steps)

So if the pt. wears underwear, zipper pants, and socks there would be 9 steps and each step would be worth 11%

A brief or pull-up can only be considered underwear if the pt. insists on wearing them as such and they have no history of incontinence. If this happens, please chart it in comments.

Modified Independent – pt. uses a device such as a dressing stick, reacher, long handled shoe horn, sock aid, button hook, velcro fasteners that are alterations to the normal clothing.

Pt. needs an assistive device (walker, etc.) for standing to don/doff clothing to/from waist.

Pt. requires more than a reasonable amt. of time.

SBA – pt. needs SBA for safety, cues, or coaxing.

Pt. needs help obtaining clothing, applying prosthesis, setting out dressing equipment.

TED hose are NOT considered socks. If the pt. can do everything independently except needs

TED hose put on, they can be SBA.

MIA – pt. requires steadying assist and/or completes 75-100% of tasks.

Pt. needs contact guard assist.

Pt. needs only incidental help such as buttons, zippers, snaps.

MOA – pt. completes 50-74% of the task

MAA – pt. completes 25-49% of the task

Total – Pt. completes <25% of the task The pt. requires assistance from 2 staff to dress.

Toileting – includes maintaining perineal hygiene and adjusting clothing before and after using a toilet, commode, bedpan, or urinal.

Only rated during a continent episode.

If pt. is wearing a hospital gown or dress, consider if pt. is able to move gown/dress out of the way and put it back in place.

For colostomy steps are adjusting clothing before and after emptying and cleansing/ wiping the end of the bag after emptying (each step 33%).

For urinal, steps are adjusting clothing before and after using and placing and removing urinal (each step 25%).

Independent – pt. cleanses himself after voiding and bowel movements and adjusts clothing before and after using the toilet, commode, bedpan, or urinal

Modified independent – pt. uses a prosthesis/orthosis or equipment (wiping stick, toilet safety frame, walker, reacher) to complete toileting independently.

Pt. takes more than a reasonable amt. of time.

SBA – pt. needs SBA for safety, cueing or coaxing or needs assistance to apply orthoses or assistive/adaptive equipment or open packages

MIA – pt. needs steadying assistance to perform all tasks independently.

Pt. attempts the task, but needs assistance to complete for thoroughness, or need assistance with feminine hygiene products.

Pt. needs contact guard assist.

MOA – Pt. needs help with pants up, pants down OR wiping

MAA – Pt. needs help with 2 of the following: pants up, pants down OR wiping

Total – Pt. needs help with up, pants down AND wiping

Transfers

Bed Transfer – from lying in bed to sitting at the edge of the bed and vice versa

Modified independent – pt. raises the head of the bed independently to assist with transferring.

Pt. uses the bedrail, leg lifter, or bed wedge to get from supine to/from sitting.

Pt. requires more than a reasonable amt. of time.

SBA - pt. needs SBA for safety, cues, or coaxing.

Staff positions or applies adaptive or assistive equipment.

Pt's primary mode of locomotion is a w/c and the pt. requires staff to lock and /or unlock brakes, lift/lower/remove and/or replace foot rests and/or remove and /or replace arm rests.

MIA - pt. requires steadying assist and/or completes 75-100% of tasks.

Pt. needs contact guard assist.

The pt. requires assistance to get only one leg into and/or out of bed.

The pt. requires assistance with the trunk from supine to sit OR sit to supine

MOA - pt. completes 50-74% of the task.

The pt. requires assistance to get both legs into and/or out of bed.

Pt. requires assistance with the trunk from supine to sit AND sit to supine.

MAA - pt. completes 25-49% of the task.

Total - Pt. completes <25% of the task.

The pt. requires assistance from 2 helpers to transfer.

The pt. requires the use of lifting equipment to transfer.

Chair transfer – sitting at the edge of the bed to/from chair or w/c

Modified Independent – pt. uses a device such as walker, bed rail, etc.

Pt. requires more than a reasonable amt. of time.

SBA - pt. needs SBA for safety, cues, or coaxing.

Staff positions or applies adaptive or assistive equipment.

Pt's primary mode of locomotion is a w/c and the pt. requires staff to lock and /or unlock brakes, lift/lower/remove and/or replace foot rests and/or remove and /or replace arm rests.

MIA - pt. requires steadying assist and/or completes 75-100% of tasks.

Pt. needs contact guard assist.

Pt. only needs pivot/slide assist.

MOA - pt. completes 50-74% of the task.

The pt. requires lowering OR lifting assistance to sit down OR stand up.

MAA - pt. completes 25-49% of the task.

The patient requires lowering or lifting assistance to sit down AND stand up.

Total - Pt. completes <25% of the task.

The pt. requires assistance from 2 staff to transfer.

The pt. requires the use of lifting equipment to transfer.

The pt. requires lowering or lifting assistance to sit down AND stand up and slide/pivot assist.

Toilet Transfer – includes approach to toilet once in the BR, sitting down, and getting up from toilet. Includes w/c set-up (locks/unlocks brakes, lifts/lowers foot rests, and/ or removes/replaces arm rests) if primary mode of locomotion is w/c.

Modified Independent – pt. uses a device such as toilet safety frame (grab bars), riser, walker etc.

Pt. requires more than a reasonable amt. of time.

SBA - pt. needs SBA for safety, cues, or coaxing.

Staff positions or applies adaptive or assistive equipment.

Pt. primary mode of locomotion is a w/c and the pt. requires a helper to lock and /or unlock brakes, lift/lowers/remove and/or replace foot rests and/or remove and /or replace arm rests.

MIA - pt. requires steadying assist and/or completes 75-100% of tasks.

Staff provides assistance with only one leg.

Pt. needs contact guard assist.

Pt. only needs pivot/slide assist.

MOA - pt. completes 50-74% of the task.

The pt. requires lowering OR lifting assistance to sit down OR stand up.

MAA - pt. completes 25-49% of the task.

The patient requires lowering or lifting assistance to sit down AND stand up.

Total - Pt. completes <25% of the task.

The pt. requires assistance from 2 helpers to transfer.

The pt. requires the use of lifting equipment to transfer.

The pt. requires lowering or lifting assistance to sit down AND stand up AND slide/pivot assist.

Tub/shower transfer – Tub includes getting in and out of a tub (therefore, unless we are transferring the pt. in the launch pad, rm. 218 or the tub in the OT area, it really isn't a true tub transfer). Shower includes getting in and out of a shower.

Modified Independent – pt. uses a device such as grab bars, bench, shower chair, etc.

Pt. requires more than a reasonable amt. of time.

SBA - pt. needs SBA for safety, cues, or coaxing.

If pt's primary mode of locomotion is w/c and requires staff to lock and unlock brakes, lift/lowers/remove/replace foot rests, remove/replace arm rests and/or position a sliding board.

MIA – pt. requires steadying assist and/or completes 75-100% of tasks.

Pt. requires steadying and/or assistance with one leg in or out of tub/shower.

Pt. needs contact guard assist.

Pt. only needs pivot/slide assist.

MOA - pt. completes 50-74% of the task.

Pt. requires lifting assistance to either come to a standing position OR lower to a sitting position and/or assistance with both legs in/out of tub/shower.

MAA - pt. completes 25-49% of the task.

Pt. requires lifting assistance to stand AND lowering assistance to sit.

Total - Pt. completes <25% of the task.

The pt. is transferred into a wheeled shower chair and pushed into the shower. The pt. requires assistance from 2 helpers to transfer.

The pt. requires lowering or lifting assistance to sit down AND stand up and slide/pivot assist.

Locomotion

Walk – includes walking on a level surface once in a standing position. The distance is calculated without rest breaks.

Independent – pt. walks a minimum of 150 ft. in a reasonable time, without assistive devices.

Pt. performs independently and safely.

Modified Independent – pt. walks a minimum of 150 ft., but uses a brace, prosthesis on leg, special adaptive shoes, cane, crutches, or walker.

Takes more than a reasonable amt. of time to complete the activity or there are safety considerations.

SBA – pt. requires SBA, cueing, or coaxing to go a minimum of 150 ft.

EXCEPTION: household ambulation. Pt. walks only short distances (minimum of 50 ft.) independently with or without a device.

The activity takes more than a reasonable amt. of time to complete the activity or there are safety considerations.

MIA – Pt. performs 75-100% of walking effort to go a minimum of 150 ft.

Pt. needs contact guard assist or hand held assist.

MOA – Pt. performs 50-74% of walking effort to go a minimum of 150 ft.

MAA – Pt. performs 25-49% of walking effort to go a minimum of 50 ft. and requires the assistance of only one person.

Total – Pt. performs less than 25% of effort

Requires the assistance of 2 people

Walks less than 50 ft.

Wheelchair – includes using a manual or motorized wheelchair on a level surface once in a seated position. Pt. can't be independent for this mode of locomotion because the w/c is a device. The distance is calculated without rest breaks.

Modified independent – pt. wheels a minimum of 150 ft. in a reasonable time, turns around, maneuvers the chair to a table, bed, toilet, negotiates at least a 3% grade and maneuvers on rugs and over door sills. Performs independently and safely.

SBA - pt. requires SBA, cueing, or coaxing to go a minimum of 150 ft.

EXCEPTION: household locomotion. Pt. travels only short distances (minimum of 50 ft.) with a manual or motorized w/c independently.

Pt. requires more than a reasonable amt. of time.

MIA - Pt. performs 75-100% of locomotion effort to go a minimum of 150 ft.

MOA – Pt. performs 50-74% of locomotion effort to go a minimum of 150 ft.

MAA – Pt. performs 25-49% of locomotion effort to go a minimum of 50 ft. and requires the assistance of only one person.

Total – Pt. performs less than 25% of effort

Requires the assistance of 2 people

Wheels less than 50 ft.

Staff wheels pt. from one location to another.

Stairs – includes going up and down 12-14 stairs (1 flight) indoors in a safe manner

Independent – pt. goes up and down one flight of stairs without any type of handrail or support and does so independently and safely.

If pt. requires different levels of assistance for ascending and descending the stairs, record the lower rating.

Pt. "bumps" up and/or down a flight of stairs independently without a device on their bottom.

Don't consider the amt. of assist needed to sit on a step or stand up from a step.

Modified independent – pt. uses a stair lift independently

Pt. "bumps" up and/or down one flight of stairs independently with a device on their bottom.
Don't consider the amt. of assist needed to sit on a step or stand up from a step.

Pt. goes up and down at least one flight of stairs but requires a side support, handrail, cane, or portable supports.

The activity takes more than a reasonable amt. of time to complete the activity or there are safety considerations.

SBA - Pt. requires SBA, cueing, or coaxing to go up and down one flight of stairs.

EXCEPTION: household ambulation. Pt. goes up and down 4-6 stairs independently, with or without a device.

MIA - Pt. performs 75-100% of effort to go up and down one flight of stairs.

Pt. needs contact guard assist or hand held assist.

MOA - Pt. performs 50-74% of effort to go up and down one flight of stairs.

MAA - Pt. performs 25-49% of effort to go up and down 4-6 stairs, and requires the assistance of only one person.

Total - Pt. performs less than 25% of effort

Pt. requires the assistance of 2 people.

Pt. goes up and down less than 4 stairs.

Pt. uses a stair lift that is operated by a helper.

Appendix B

The Volitional Questionnaire (VQ). (see following pages)

Volitional Questionnaire (Form A- Single Observation)

Client:		Therapist:					
Age:	Gender: M F	Date:					
Diagnosis:		Facility:					
Setting: _____		Ratings					Comments
Shows curiosity		P	H	I	S	N/O	
Initiates actions/tasks		P	H	I	S	N/O	
Tries new things		P	H	I	S	N/O	
Shows preferences		P	H	I	S	N/O	
Shows that an activity is special or significant		P	H	I	S	N/O	
Indicates goals		P	H	I	S	N/O	
Stays engaged		P	H	I	S	N/O	
Shows pride		P	H	I	S	N/O	
Tries to solve problems		P	H	I	S	N/O	
Tries to correct mistakes		P	H	I	S	N/O	
Pursues activity to completion/accomplishment		P	H	I	S	N/O	
Invests additional energy / emotion / attention		P	H	I	S	N/O	
Seeks additional responsibilities		P	H	I	S	N/O	
Seeks challenges		P	H	I	S	N/O	
Key: P = Passive H = Hesitant I = Involved S = Spontaneous N/O = No opportunity to observe							

Volitional Questionnaire (Form C- Multiple Observations)

Client:	Facility:															
Age:	Therapist:															
Gender:	Diagnosis:															
	Date:				Date:				Date:				Date:			
	Setting:				Setting:				Setting:				Setting:			
Shows curiosity	P	H	I	S	P	H	I	S	P	H	I	S	P	H	I	S
Initiates actions/tasks	P	H	I	S	P	H	I	S	P	H	I	S	P	H	I	S
Tries new things	P	H	I	S	P	H	I	S	P	H	I	S	P	H	I	S
Shows preferences	P	H	I	S	P	H	I	S	P	H	I	S	P	H	I	S
Shows that an activity is special or significant	P	H	I	S	P	H	I	S	P	H	I	S	P	H	I	S
Indicates goals	P	H	I	S	P	H	I	S	P	H	I	S	P	H	I	S
Stays engaged	P	H	I	S	P	H	I	S	P	H	I	S	P	H	I	S
Shows pride	P	H	I	S	P	H	I	S	P	H	I	S	P	H	I	S
Tries to solve problems	P	H	I	S	P	H	I	S	P	H	I	S	P	H	I	S
Tries to correct mistakes	P	H	I	S	P	H	I	S	P	H	I	S	P	H	I	S
Pursues activity to completion/accomplishment	P	H	I	S	P	H	I	S	P	H	I	S	P	H	I	S
Invests additional energy/emotion/attention	P	H	I	S	P	H	I	S	P	H	I	S	P	H	I	S
Seeks additional responsibilities	P	H	I	S	P	H	I	S	P	H	I	S	P	H	I	S
Seeks challenges	P	H	I	S	P	H	I	S	P	H	I	S	P	H	I	S
Key: P = Passive H = Hesitant I = Involved S = Spontaneous																
Comments																

Volitional Questionnaire (Form D- Volitional Continuum)

Increased Sense of Ability and Control

Level of Volitional Development	Client: _____ Date: ____ / ____ / ____ Setting: _____	VQ Ratings				
		Needs more support → Needs less support				
Achievement	Seeks Challenges	N/O	P	H	I	S
	Seeks Additional Responsibilities	N/O	P	H	I	S
	Invests Additional Energy/ Emotion/Attention	N/O	P	H	I	S
	Pursues Activity to Completion/Accomplishment	N/O	P	H	I	S
Competency	Tries to Correct Mistakes	N/O	P	H	I	S
	Tries to Solve Problems	N/O	P	H	I	S
	Shows Pride	N/O	P	H	I	S
	Stays Engaged	N/O	P	H	I	S
Exploration	Indicates Goals	N/O	P	H	I	S
	Shows that an Activity is Special or Significant	N/O	P	H	I	S
	Shows Preferences	N/O	P	H	I	S
	Tries New Things	N/O	P	H	I	S
	Initiates Actions/Tasks	N/O	P	H	I	S
	Shows Curiosity	N/O	P	H	I	S

N/O= No Opportunity: No opportunity to observe
 P= Passive: Does not show behavior even with support, structure, or encouragement
 H= Hesitant: Shows behavior with maximal amount of support, structure, or encouragement
 I= Involved: Shows behavior with minimal amount of support, structure, or encouragement
 S= Spontaneous: Shows behavior without support, structure, or encouragement

Interpretation of Volitional Levels

Exploration Level: Client has a desire to engage in the environment for pleasure and enjoyment, and to make discoveries in low risk situations.
 Competency Level: Client has a drive to actively interact and influence the environment, practice skills, and meet performance standards.
 Achievement Level: Client strives to increase their capacity to do a challenging task and to have successful performance outcomes.

Spaces

Setting in which the client was observed: _____

Check all boxes that apply for this observation:

Location: Indoors Outdoors

Lighting: Natural Artificial

Sound: Quiet Noisy

Space for movement:

Small Adequate

Additional Factors Influencing Volition:

Objects

Check all boxes that apply for this observation:

Familiar Unfamiliar

Natural Fabricated

Similar Dissimilar

Simple Complex

Few Many

Additional Factors Influencing Volition:

Social Environment

Check all boxes that apply for this observation:

Individual One-to-One

Group: (*Number of individuals*): _____

Chosen by client Pre-selected

Familiar people Unfamiliar people

Peers Supervisors/Supervising Professionals

Additional Factors Influencing Volition:

Occupational Forms/Tasks

Activity in which the client was engaged:

Check all boxes that apply for this observation:

Familiar Unfamiliar

Chosen by client Pre-selected

Structured Unstructured

Adequate Challenge Inadequate Challenge

Additional Factors Influencing Volition:

Appendix C

The General Self-Efficacy (GSE) Scale. (see following pages)

General Self-Efficacy (GSE) Scale

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For each of the following statements, please circle the choice that is closest to how true you think it is for you. The questions ask about your opinion. There are no right or wrong answers.

1. I can always manage to solve difficult problems if I try hard enough.

1 = Not at all true 2 = Hardly true 3 = Moderately true 4 = Exactly true

2. If someone opposes or is against me, I can find a way to get what I want.

1 = Not at all true 2 = Hardly true 3 = Moderately true 4 = Exactly true

3. It is easy for me to stick to my plans and accomplish my goals.

1 = Not at all true 2 = Hardly true 3 = Moderately true 4 = Exactly true

4. I am confident that I could deal efficiently with unexpected events

1 = Not at all true 2 = Hardly true 3 = Moderately true 4 = Exactly true

5. Thanks to my resourcefulness and ability to figure things out, I know how to handle unexpected or unforeseen situations.

1 = Not at all true 2 = Hardly true 3 = Moderately true 4 = Exactly true

6. I can solve most problems if I invest the necessary effort.

1 = Not at all true 2 = Hardly true 3 = Moderately true 4 = Exactly true

7. I can get what I want from people if I make them feel sorry for me.

1 = Not at all true 2 = Hardly true 3 = Moderately true 4 = Exactly true

8. I can remain calm when facing difficulties because I can rely on my coping abilities.

1 = Not at all true 2 = Hardly true 3 = Moderately true 4 = Exactly true

9. When I am confronted with a problem, I can usually find several solutions

1 = Not at all true 2 = Hardly true 3 = Moderately true 4 = Exactly true

10. If I am in trouble, I can usually think of a solution.

1 = Not at all true 2 = Hardly true 3 = Moderately true 4 = Exactly true

11. I can usually handle whatever comes my way.

1 = Not at all true 2 = Hardly true 3 = Moderately true 4 = Exactly true

12. I spend time identifying long-range goals for myself.

1 = Not at all true 2 = Hardly true 3 = Moderately true 4 = Exactly true

13. If I want something from someone I should have a positive attitude.

1 = Not at all true 2 = Hardly true 3 = Moderately true 4 = Exactly true

14. I feel in charge of making things happen.

1 = Not at all true 2 = Hardly true 3 = Moderately true 4 = Exactly true

15. I feel responsible for my own life.

1 = Not at all true 2 = Hardly true 3 = Moderately true 4 = Exactly true

16. I feel driven by my personal values.

1 = Not at all true 2 = Hardly true 3 = Moderately true 4 = Exactly true

17. I am driven by a sense of purpose.

1 = Not at all true 2 = Hardly true 3 = Moderately true 4 = Exactly true

18. Most things happen to me because I am lucky.

1 = Not at all true 2 = Hardly true 3 = Moderately true 4 = Exactly true

19. I am able to choose my own actions.

1 = Not at all true 2 = Hardly true 3 = Moderately true 4 = Exactly true

20. I focus my efforts on things that I can control.

1 = Not at all true 2 = Hardly true 3 = Moderately true 4 = Exactly true

21. There are abundant opportunities that await me.

1 = Not at all true 2 = Hardly true 3 = Moderately true 4 = Exactly true