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**IDENTIFICATION OF ADJUNCTIVE METHODS, PERFORMANCE
SKILLS AND LEISURE AND PRE-VOCATIONAL ACTIVITIES
USED IN OCCUPATIONAL
THERAPY**

**A Thesis
Presented to
The Faculty of the Department of Occupational Therapy
San Jose State University**

**In Partial Fulfillment
of the Requirements for the Degree
Master of Science**

**By
Suzanne McKenna-Stukas
May, 1995**

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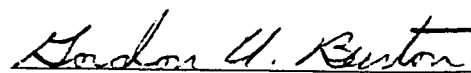
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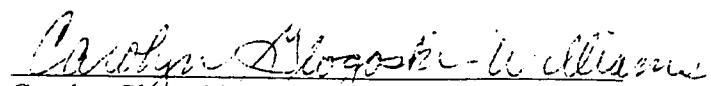
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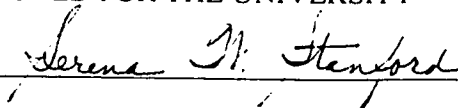


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ABSTRACT

IDENTIFICATION OF ADJUNCTIVE METHODS, PERFORMANCE SKILLS AND LEISURE AND PRE-VOCATIONAL ACTIVITIES USED IN OCCUPATIONAL THERAPY

by Suzanne McKenna-Stukas

This research identified adjunctive methods, performance skills, and leisure and pre-vocational activities used most frequently, occasionally and seldom/never by occupational therapists in physical and psychosocial disability areas of practice. These methods, skills, and activities were compared for similarity of use in both areas of practice. Data analysis revealed that occupational therapists participating in physical disability practice used adjunctive methods and performance skills more frequently than leisure and pre-vocational activities. Occupational therapists in psychosocial disability practice used performance skills and leisure and pre-vocational activities more frequently than adjunctive methods. Therapists in psychosocial practice identified frequently used leisure and pre-vocational activities, there were leisure and pre-vocational activities identified as seldom/never used in both physical and psychosocial disability practice. The results may be useful to implement changes in curriculum to concur with most frequently and occasionally used adjunctive methods, performance skills, and leisure and pre-vocational activities and eliminate those seldom/ never used.

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TABLE OF CONTENTS

TITLE PAGE	i
COPYRIGHT.....	ii
SIGNATURE PAGE.....	iii
ABSTRACT.....	iv
ACKNOWLEDGMENTS.....	v
TABLE OF CONTENTS	vii
LIST OF TABLES.....	ix
CHAPTER 1	
INTRODUCTION.....	1
Purpose.....	1
Statement of the Problem.....	1
Objective and Questions	3
Definitions	4
Significance of the Study.....	6
Assumptions.....	7
Limitations.....	7
CHAPTER 2	
REVIEW OF THE LITERATURE.....	9
The Dilemma of Purposeful Activity.....	12
The Dilemma of Purposeful Activity Complicated by Activity Versus Modality	13
Comparison of Physical and Psychosocial Areas of Treatment.....	19
Trends in Psychosocial Areas	20
Trends: Activities versus Modalities.....	23
Summary.....	30

CHAPTER 3	
RESEARCH PROCEDURE, DATA ANALYSIS, AND RESULTS	32
Procedure	32
Data Analysis and Presentation of Data.....	34
Results.....	49
CHAPTER 4	
SUMMARY AND IMPLICATIONS.....	53
Implications for Curriculum Review.....	55
REFERENCES.....	60
APPENDIX A.....	63
APPENDIX B.....	69

LIST OF TABLES

1.	Physical Disabilities: Adjunctive Methods Identified by Occupational Therapist Ranked Usually/Frequently to Seldom/Never	35
2.	Physical Disabilities: Performance Skills Identified by Occupational Therapist Ranked Usually/Frequently to Seldom/Never	36
3.	Physical Disabilities: Leisure and Pre-Vocational Activities Identified by Occupational Therapist Ranked Usually/Frequently to Seldom/Never	39
4.	Psychosocial Disabilities: Adjunctive Methods Identified by Occupational Therapist Ranked Usually/Frequently to Seldom/Never	42
5.	Psychosocial Disabilities: Performance Skills Identified by Occupational Therapist Ranked Usually/Frequently to Seldom/Never	43
6.	Psychosocial Disabilities: Leisure and Pre-Vocational Activities Identified by Occupational Therapist Ranked Usually/Frequently to Seldom/Never	46

Chapter 1

INTRODUCTION

Purpose

The purpose of this study was threefold: 1) to determine the adjunctive methods, performance skills and leisure and pre-vocational activities used by occupational therapists in clinical practice; 2) to identify the adjunctive methods, performance skills, and leisure and pre-vocational activities most frequently used, occasionally, and seldom/never used by occupational therapists in clinical practice; and 3) to compare the similarities and differences between the adjunctive methods, performance skills, and leisure and pre-vocational activities that are utilized in physical disabilities and psychosocial disabilities areas of practice in occupational therapy.

Statement of the Problem

The foundations of occupational therapy are grounded on the premise that activity is a key stepping stone from disability to increased ability or improved health. The ability to select from a variety of media or purposeful activities in treatment planning makes occupational therapy both unique and challenging and potentially overwhelming and confusing for the new therapist in the selection of adjunctive methods, performance skills, and leisure and pre-vocational activities. A study by Bissell and Mailloux (1981)

indicated that there was a decrease in the utilization of craft activities and an increase in the use of alternative techniques and modalities. Bissell and Mailloux (1981) described changes in scientific advancement and overall medical progress which have brought changes in occupational therapy practice. These changes have emphasized technique rather than theory which has given birth to the use of adjunctive methods such as icing, massage, exercise, and splinting that appear more precise than purposeful activities which include leisure and pre-vocational activities. The theory upon which occupational therapy is based relates to the use of purposeful activity to effect change that meets therapeutic goals. Current occupational therapy practice may not consistently incorporate purposeful activity into the treatment plan to achieve therapeutic goals. Occupational therapists evaluate and treat the whole person; however, the profession is complicated by the division of practice into serving patients and clients with physical and psychosocial disabilities. A problem for some new therapists is occupational therapy's lack of a single defined area of practice. Therapists are employed in a variety of work settings where different adjunctive methods, performance skills and leisure and pre-vocational activities are required to function. New occupational therapists may have a problem identifying adjunctive methods, performance skills and leisure and pre-vocational activities advocated for current practice. There is a need to identify the adjunctive methods, performance skills, and leisure and pre-vocational activities which

are in current use by occupational therapists in practice to provide data for assessing the status of curricular offerings and provide data for further research.

Objectives and Questions

The objective of this study was to identify most frequently used, occasionally used, and seldom/never used adjunctive methods, performance skills, and leisure and pre-vocational activities used in occupational therapy clinical practice. The following questions were generated for this study:

1. What are the adjunctive methods, performance skills, and leisure and pre-vocational activities used most frequently, occasionally, and seldom/never by occupational therapists whose primary practice is physical dysfunction?
2. What are the adjunctive methods, performance skills, and leisure and pre-vocational activities used most frequently, occasionally, and seldom/never by occupational therapists whose primary practice is psychosocial dysfunction?
3. What are the similarities among the adjunctive methods, performance skills, and leisure and pre-vocational activities used in occupational therapy practice for physical and psychosocial disabilities?

Definitions

Definitions of terms used in this study include:

Adjunctive methods: Techniques used by occupational therapists which involve passive or active participation from the client/patient to facilitate recovery or change abnormal disease/ or dysfunctional process to restore normal function. These techniques may not be meaningful to the client/patient or involve goal achievement to or for the client/patient.

Enabling activities: Activities involving active participation from the client/patient in achieving a specific goal; however, the task may not be meaningful to the client/patient in functional terms (i.e. use of a dressing practice board). These activities facilitate motor movement, strength, co-ordination, and cognitive skills to enable clients/patients to progress to a higher level of functional ability.

Leisure/pre-vocational activities: Activities which involve active participation from the client/patient, lead to goal achievement (end product or accomplishment), and are meaningful/purposeful to the client/patient. Leisure activities refer to the recreational aspect of the activity. Pre-vocational activities describe those which may assist individual in occupational or vocational aspects of the client/patients life. Occupation in this context may refer to occupation of time in ones daily life or occupation in terms of work/ or vocation.

Occupational therapist: A health professional whose focus is on the evaluation and treatment of disabilities and dysfunction to restore and/or enhance function, facilitate learning of skill to increase or maximize functional independence.

Occupational therapy is the art and science of directing man's participation in selected tasks to restore, reinforce and enhance performance, facilitate learning of those skills and functions essential for adaptation and productivity, diminish or correct pathology and to promote and improve health. Its fundamental concern is the development and maintenance of the capacity throughout the life span, to perform with satisfaction to self and to others, those tasks and roles essential to productive living and to the mastery of self and environment. (Council on Standards and Executive Board of the American Occupational Therapy Association, 1972)

Performance skills: Tasks which assist the client/patient to achieve occupational skill components of sensory, motor, psychological, social and cognitive functioning. The occupational skill may or may not be meaningful to the client/patient; however, the individual is evaluated/ and treated based upon their ability to perform at a particular task.

Physical dysfunction: For the purpose of this study physical dysfunction refers to problems of physical functioning that constitute an area of practice for

occupational therapy. Individuals who are prevented from achieving their maximal independent functioning because of a physical disability are appropriate candidates for occupational therapy services. Treatments are selected to aid the client in eliminating or adjusting to the physical disability and/or restructuring his or her lifestyle to achieve maximal independent functioning.

Psychosocial dysfunction: For the purpose of this study, psychosocial dysfunction will refer to problems related to psychological or psychosocial disability that constitute an area of practice in occupational therapy. Individuals who are prevented from achieving their maximal independent functioning because of a psychological or social disability are appropriate candidates for occupational therapy services. Treatments are selected to aid the client in ameliorating or adjusting to the disability and/or to modify his or her lifestyle to achieve maximal independent functioning.

Significance of the Study

The significance of the study is that it provides information on the adjunctive methods, performance skills, and leisure and pre-vocational activities which are most frequently used, occasionally, and seldom/never used by occupational therapists in the treatment of two major populations of clients. Currently there appears to be a need to determine whether there is a gap between the educational background of entry level therapists and the knowledge of adjunctive methods, performance skills, and leisure and

pre-vocational activity skills needed for clinical practice in these areas. (Fox 1991) An accurate data base to determine current practice will be useful for curriculum development and for future research.

Assumptions

The researcher's assumptions were:

- 1) That there will be few similarities in adjunctive methods, performance skills, and leisure and pre-vocational skills used in occupational therapy practice for physical and psychosocial disabilities.
- 2) That the data reported by the respondents reflects actual adjunctive methods, performance skills and leisure and pre-vocational activities used in practice.

Limitations

The limitations of this study were as follows:

- 1) The survey from which the results of this study were taken was performed in 1988. The results of this research may not be a reflection of the most current use of modalities, performance skills, and leisure and pre-vocational activities used in occupational therapy today.
- 2) The fact that the survey had already been performed limited the methods, skills and activities which were listed or not listed on the survey. However, blank spaces were made available for comments or additional methods, skills and activities to be stated.

- 3) The survey was analyzed by dividing and comparing physical disabilities and psychosocial disability areas of practice. Sub-specialty areas such as pediatrics, geriatrics and hand therapy were not identified and analyzed which was beyond the scope of this study.

Chapter 2

REVIEW OF THE LITERATURE

Occupational therapy has grown, changed and developed over the years. This literature review will provide an historical overview of occupational therapy, changes which have occurred in occupational practices in physical and psychosocial areas, and of the development and dilemmas which are experienced in current practice.

Since the time of its inception to the current practice of occupational therapy, the wide use of media and purposeful activity has provided some of its practitioners with the perception of “jack of all trades and master of none.” The variety of treatment methodologies and activities used as therapy media makes occupational therapy challenging and for some overwhelming and confusing as they attempt to provide the patient with the most comprehensive and appropriate treatment. (Bissell & Mailloux, 1981; Eliason & Gohl-Giese, 1979)

Studies have indicated that occupational therapy has experienced a state of crisis. Kielhofner and Burke (1977), Bissell and Mailloux (1981), Fidler (1981), Shannon (1977) described occupational therapy in "crisis" characterized by confusion over the role and identity of the profession. These studies attempted to describe the inadequacies of using techniques to maximize function/adaptation while ignoring the holistic view of treatment with purposeful activity at the base of practice.

The following is a brief chronology of the development and changes in occupational therapy relative to craft and activity use:

1900-1920 In the early years of occupational therapy's development as a result of the casualties of World War I, Woodside (1971) stated "Occupational therapy's role in rehabilitation was one of using crafts to reactivate the minds and motivation of the mentally ill and the limbs of the veterans starting on their way to vocational training" (pp. 226-230). Occupational therapists began as reconstruction aides with the focus on treatment/rehabilitation of the mentally ill and veterans of war. The reconstruction aides were trained as either physical therapy aides or as occupational therapy aides whose purpose was to furnish forms of occupation to convalescents with long term illnesses and to give patients the therapeutic benefit of activity. (Huss 1981) One hypothesis which has greatly influenced the profession is: "That man, through the use of his hands as they are energized by mind and will, can influence the state of his own health" (Reilly, M. 1962). Crafts were a very important part of activity programs which were implemented during this period.

1920-1930 During the formative years, after the transition from reconstruction aides to occupational therapists, therapists were complacent. The operating principle was that it was good for disabled people to keep active and busy doing things they

enjoyed (Bissell & Mailloux, 1981). Bissell and Mailloux (1981) reflected that occupational therapists used activities as the fundamental treatment modality.

1930-1940 With the decline of the economy, medical costs were cut and staff was limited. The therapists were insecure in their ability to retain a viable profession and aligned with the American Medical Association (AMA) to implement Minimum Standards of training to "establish standards for training institutions and to accredit each new school....the powerful AMA came to the rescue" (Rerek, 1971).

1940-1960 The casualties of WW II paved the way for the rehabilitation movement. There was a shift in the trend from activities, especially in the physical disabilities area of practice, to exercise and modalities which were more traditionally associated with physical therapy. Education shifted from arts and crafts towards science (Mosey, 1971). Mosey reflected that therapists "borrowed" techniques from other disciplines. These techniques included progressive resistive exercises, neuromuscular facilitation, activities of daily living (ADL), prosthetic training, and fabrication of orthotic devices. Although there was an increased use of techniques, the profession neglected to incorporate these techniques into its philosophical base (Mosey, 1971).

1960-1980 The 1960's brought an era of questioning of the role of the occupational therapist and a need for re-organization and restructuring within the profession

(Diasio, 1971). Occupational therapy practice settled into an era that incorporated reductionist thinking and approaches into its practice. Occupational therapists within the area of physical disabilities developed skills with increased use of the techniques which reflected the progression of new technology. At the same time they also demonstrated increased concern for the psychological and social aspects of treatment with emphasis on quality health care services. These concerns continued in the mental health and physical disability setting into the 1970's (Mosey, 1973; Wiemer, 1972). Most recent studies in the 1980's demonstrate changes in scientific advancement and overall medical progress which emphasized technique or modalities (Bissell & Mailloux, 1981). Purposeful activities used to achieve functional outcomes have been replaced with modalities more closely identified with the knowledge base and practices of other professions (West, 1984).

The Dilemma of Purposeful Activity

Throughout the 60's and to the present, there has been a pervasive concern regarding discrepancies/inadequacies in the philosophical base of occupational therapy. The dilemma may stem from lack of a clear definition of purposeful activity. Steinbeck (1986) studied opinions of numerous authors who analyzed the theory of purposeful activity using a variety of approaches. Dunton (1918) stated that occupation must have some useful end to be an effective tool in the treatment of mental and physical

disabilities. King (1978) viewed purposeful activity as part of an adaptive process that characterizes individual development and mastery of the environment. Fidler and Fidler (1978) were concerned with the purposeful action of "doing" as a means of self actualization. DiJoseph (1982) identified purposeful activity in terms of a triad of mind, body and environment, entwined and interdependent on each other for effective treatment. She also proposed that one can achieve greater performance by facilitation of that process, through the utilization of appropriate modalities.

Trombly (1983) reasoned that motivation is the key factor in determination or persistence with which one pursues a goal. She proposed that a patient provided with interest sustaining activities is likely to pursue those activities longer than would be expected with less interesting activities or exercises.

Steinbeck (1986) found that his study of the therapeutic value of the process of purposeful activity and the modalities utilized in the process substantiated the philosophy of occupational therapy. He found that purposeful activity had a positive effect on performance, as measured by the number or repetitions of an activity when purposeful and non-purposeful activities were compared.

The Dilemma of Purposeful Activity Complicated by Activity Versus Modality

Purposeful activity was called a "vague" term by English, Kosch, Silverman, and Walker (1982). These authors joined in opposition against the entry level role delineation as defined by the American Occupational Therapy Association (AOTA) in

1981 (AOTA, 1981). These authors responded to the trend in 1981 to define more clearly the occupational therapists' role which the AOTA developed the Entry Level Role Delineation. Entry Level Role Delineation described program planning to restore performance as necessary to minimize debilitation (as opposed to restoring or improving physical function) and to determine activities to attain these goals (AOTA, 1981). This delineation suggested limiting therapeutic methods to the use of only purposeful activities. This implied restricting occupational therapy to restoration by the use of activities which would exclude exercises, physical modalities, or corrective splinting to achieve the ultimate goal of maximum function. English, Kosch, Silverman, and Walker (1982) agreed/acknowledged that a degree of expertise is required to perform effectively in these areas and that the foregoing comments are not applicable to the entry-level therapist, however, the level of expertise is applicable to the therapist with a minimum of 1 to 3 years of full time experience in the physical disabilities practice area. They commented that post-graduate training may be necessary for performing certain techniques.

The AOTA position papers on "purposeful activities" were presented and approved by the Representative Assembly in April, 1983 (AOTA, 1983). As stated in this paper, an individual who is engaged in purposeful activity "directs attention to the task itself, rather than to the internal processes required for achievement of the task. Activities may yield immediate results or require sustained effort and multiple repetition.

Purposeful activities, influenced by the individual's life roles, have unique meaning to each person" (pp.805-806). In taking into account the client's disability as well as his/her current level of performance, the AOTA states that the occupational therapist determines whether the activity will be adapted to compensate for a functional deficit or to promote restoration. With this determination, the AOTA stated that "Purposeful activities cannot be routinely prescribed" (pp.805-806). Thus, the occupational therapist may present a series of activities or change the steps within the activity. Such grading provides skill development and therapeutic exercise to respond to the dynamic changes of the client.

The use of techniques such as hydrotherapy, exercise and splinting are seen by some authors as a threat to the valued use of purposeful activity. West (1984) questioned, for example, occupational therapists' use of these techniques in hand rehabilitation. She questioned, "Why the denial of traditional media and their replacement with modalities which is more closely identified with the knowledge base of other disciplines and the practice of other professions?" (p.6).

A recent study by Gritzer and Arluke (1985) found that social scientists propose that occupational therapy's very nature is muddled, that it is a specialty that has not defined its commodity, and that it is not understood by society. The authors presented a challenge to the occupational therapists: "Unless occupational therapists can correct their course in the rehabilitation marketplace, they will remain subordinate to other groups in the division of labor" (p.145). The study further indicated that recent attempts to improve

the commodity definition have only further "muddled" the very nature of the profession. Little consensus exists today as to what distinguishes this profession from the others. Gilfoyle (1988) agreed stating, "I believe we will continue in our muddled state until our scientific endeavors support our product or service. In defining our commodity, our profession must increase its scientific base about the therapeutic use of occupation, transfer that knowledge to methods that enhance an individual's productivity, and then apply these truths to a marketable product-cost-effective service" (p.145).

DiJoseph (1982) attempted to integrate philosophy and theory into practice by looking at activity in terms of body, mind, and environment. DiJoseph described occupational therapists as unique in their ability to look at mind, body, and environment collectively and to elicit an adaptive response through the use of appropriate stimuli. These stimuli are interpreted by the nervous system as meaningful. This "meaning" being indicative of purposeful activity or occupation leading to competence. Thus, activity brings theory and practice together as a primary treatment tool. Activity must be integrated into the totality of behavior considering mind, body, and environment in all areas of practice.

In the analysis of various positions which attempted to define purposeful activity, it seemed evident that occupational therapists defined their practice by the tools they used rather than by defining the practice in terms of what is done to enhance or maximize an individual's functional independence (Mosey, 1981). Purposeful activity may be

defined in terms of unique directions of individual patients and the enabling of patients towards enhanced growth and development by involvement and organization of self and environment, both structural and personal (Breines, 1984). The goals must be those of the patient. Goal directed activities assume intention and purpose on the part of the individual. Breines further stated that a great deal of in the education and practice of occupational therapy has been directed toward the technology of practice and away from the early principles. This attention to tools has clouded the understanding of the pragmatic principle of personal choice upon which the profession was founded (Breines, 1984).

The problem of defining purposeful activity may stem from the fact that the modern day therapist may be ascribing different meanings to the term "purposeful activity" than did the therapist in the past. Lyons (1983) surveyed "Letters to the Editor" in the American Journal of Occupational Therapy and found that some therapists considered purposeful activities synonymous with crafts, games or activities of daily living (ADL) endeavors. Others defined the term by exclusion - they declared that purposeful activities were not exercises. This definitional dilemma did not exist in occupational therapy's infancy as described earlier in birth from the moral treatment era.

In the development of occupational therapy, the practice areas and treatment techniques grew. As therapists became involved with each new client group, they began to include an ever increasing number of treatment modalities which therapists assumed to

be an example of purposeful activity. "In so doing, the phrase 'purposeful activity' became an umbrella for a heterogeneous bag of human endeavors" (Lyons, 1983).

There are many disagreements over the use of "meaningful activities." There are also differences of opinion between therapists who argue about the usefulness of crafts, exercise or biofeedback. Breines (1984), Fidler (1981), Huss (1981) and Trombly (1982) addressed the issue of the therapeutic use of meaningful activities and it was assumed by these authors that the therapist would be competent in selecting tasks or occupations that patients viewed as meaningful using creative adaptation to further enhance skill levels (Breines, 1989).

The dilemma was further complicated by the therapists who supported exercise and modalities as "adjunctive treatments" versus the therapists who may believe that all activities used in treatment must be purposeful and meaningful to the patient.

Trombly (1982) agreed with official AOTA support of the necessity to use purposeful activity and goal directed activity (e.g. crafts, games, and ADL) which are ideal methods to improve motor performances due to the apparent motivation factor and the potential for developing feelings of competency. However, in practice, the type of purposeful activity was limited with regard to control of parameters of gradation needed to effect an improvement in strength, range of motion, and motor control. Trombly observed that most patients being seen by a therapist in the treatment of physical disabilities were at too low a level of motor ability to participate meaningfully in a task

of such complexity. The therapist must often use simple exercises and "adjunctive" treatments (splinting, exercises, biofeedback, and sensory stimulation) to enable development of the motor ability needed to engage in tasks of daily living.

Comparison of Physical and Psychosocial Areas of Treatment

Eliason and Gohl-Giese (1979) reported that observers of the occupational therapy profession have seen changes in practice that demonstrate the loss of some of the more traditional forms of treatment, such as crafts, in favor of treatment modalities borrowed from other professions. The results of a study conducted by Eliason and Gohl-Giese of 102 centers located throughout the country with more than one possible questionnaire sent to each center depending on the number of separate occupational therapy departments in the center. Therapists were asked to respond with a check mark on whether or not each treatment was used frequently, occasionally, almost never, or never, according to their own definition of each term. The survey received 193 forms with only 101 from physical dysfunction and psychiatric settings used in the study. The results indicated that needlework was an activity used 100% of the time in psychosocial area of practice, while activities of daily living (ADL) were used 100% of the time in physical disability areas of practice. Sensory integration was indicated for use by 70% of occupational therapists in treatment; even though it was a recent development in occupational therapy, it had become an integral part of programs. Passive range of motion was indicated as used by 99% of the therapists in the physical disabilities area of

practice. Specific data regarding the purpose of its use was lacking so that it is not known whether it was often used as a modality by itself or as an adjunct to other treatments. The data revealed that 92% of physical disability therapists indicated that they used activities in treatment in conjunction with active range of motion, resistive exercises and facilitation/inhibition techniques. The data also revealed that approximately 92% of physical disability therapist indicated that they used these same techniques without activities depending on the appropriateness of the situation. Finally the study indicated that 10% or less of the clinics surveyed were using activities which have been taught in traditional occupational therapy curricula, such as basketry, the bicycle saw or the printing press. From this study it was unknown whether therapists working with the physically disabled had or had not used purposeful activities with exercises. Development of new treatment areas or modalities was also indicated as part of the study. Sex education was identified by 47% of physical disabilities therapists and 40% of psychosocial disability therapists. Biofeedback was used by 37% of physical disability therapists while 10% of psychosocial therapists used biofeedback.

Trends in Psychosocial Areas

Both physical and psychosocial areas of practice are experiencing financial cuts as well as increased demand for greater efficiency and accountability of services rendered (Klyczek & Mann, 1986). Klyczek and Mann studied two day treatment centers and the differences between the two modalities of treatment namely activities therapy

versus non-active or verbal therapy used in these facilities. Subjects included 122 patients who were admitted during the 29 month study period. The results of the study were based upon 1) relapse of the individual with the number of times the individual as re-hospitalized and 2) community tenure with the number of days the patient remained in the community during the 29 month period. The two day treatment centers tested provided patients with two types of treatments. One option is activity-related, in that patients work directly on skill development through a task or activity approach. A second option emphasized a verbal approach utilizing individual or group psychotherapy with emphasis on problem solving and developing insight as to the basis of the psychiatric problems.

In the Klycek and Mann study it was shown that one offered twice as much activity therapy as verbal therapy and the other offered twice as much verbal therapy as activity therapy. It was found that clients who primarily received activity therapy achieved four times more symptom reduction, equivalent community tenure, and a 3.5 times greater relapse rate than clients who primarily received verbal therapy. In other words, patients who received activity therapy achieved a reduction in symptomatology translating into increased levels of independent functioning in community living skills; however, they were hospitalized significantly more often than those who received verbal therapy, but these hospitalizations were for shorter duration than for verbal therapy patients.

Concerns in the psychosocial areas of occupational therapy have grown over the past ten years. In 1976 an AOTA task force on mental health reported serious problems in the psychosocial sphere of practice. (Bonder 1987) The report noted that the number of occupational therapy personnel in mental health was on the decline at a time when the rest of the profession was growing. In 1984, a survey by the AOTA Division of Continuing Education found that few occupational therapists in mental health were employed outside of inpatient facilities and that only 36.1% of the respondents reported being reimbursed by third-party payers for their services. In 1985, the Commission on Manpower, as reported by the AOTA, showed employment of occupational therapists increased by more than 75% between 1977-1982; however, the number of occupational therapists in community mental health was reduced by half. Bonder (1987) proposed new areas of possible growth as employee assistance programs, boarding homes and community centers.

Barris (1984) and Kielhofner and Barris (1984) in their studies of psychosocial settings found that many therapists were leading crafts or hobby groups, social skills groups, task skills groups and leisure groups. In an article describing the current use of crafts in occupational therapy (Fox, 1991b), Sandra David, OTR, who is presently writing a chapter on the application of crafts in psychiatry for an upcoming book by Claudia Allen M.A., OTR, FAOTA presented a perspective on craft use. "When you give the patient a task that is relevant and will be used in everyday life, you are treating the whole

person. Those activities are organizing to the individual, and behavior really does change. For the task to have some meaning to them, I fit it in with their culture. I use their natural organizing abilities to optimize their function” (Fox, 1991b). David also added that unfortunately some occupational therapists are opting to conduct task groups because, quite simply, they are easier to do and involve much less clinic preparation and clean up (Fox, 1991b).

Trends: Activities versus Modalities

A recent study completed by Barris, Cordero and Christiaansen (1986) revealed an increase in the use of modalities. These modalities appeared to be similar to modalities used by other professions rather than as traditional occupational therapy treatments. (i.e., physical exercise and gestalt therapy) In another study, Bissell and Mailloux (1981) found that a large percentage of therapists who worked in physical disabilities areas of practice still used crafts. The inability to document the use of crafts and to justify their use appeared to be the predominant reason for not using them. Eliason and Gohl-Giese (1979) found that while traditional crafts were still in use, there was an increased tendency for the therapist to use a number of new treatment modalities (i.e., biofeedback and ultrasound) in their place. Barris, Cordero and Christiaansen (1986) suggested that the reasons for these changes may have been the appeal of more technological, scientific forms of treatment, the influence of colleagues who were more skilled in these techniques and a decreased educational emphasis on learning more

traditional work and play media. Thus the tendency to engage in less traditional forms of treatment may be less pronounced in psychosocial occupational therapy than it is in physical disabilities.

Barris, Cordero and Christiaansen (1986) found that while a wide array of activities were available to the occupational therapist, individuals in their study appeared to focus their treatment on daily living activities (ADL) and physical modalities, such as ranging or strengthening exercises. In comparison, crafts and art activities, games and work were not completely ignored, but appeared to be frequently utilized in psychosocial occupational therapy. The limited use of these activities in physical dysfunction did not clearly relate to therapeutic goals because the physical disability therapists who did use crafts, art or games used them for the same goals for which other respondents used exercise related modalities (Barris, Cordero, & Christiaansen 1986). This study unveiled questions as follows: Are therapists assuming that activities with the most face value (i.e., strengthening exercises to remediate musculoskeletal problems) are most effective? Are therapists assuming that other activities are not effective or as effective? Do therapists feel that patients won't value more traditional media?

Barris, Cordero, and Christiaansen (1986) cited clinical education as the predominant influence on therapists' practice. In addition, each individual department/clinic's use of activities and modalities also providing a strong influence on the therapists practice. Classroom education was cited frequently as a strong influence on

activity use, which was mentioned particularly often in the case of arts and crafts, yet these activities were used mostly by the psychosocial therapist and not the physical disabilities therapist. This may suggest that when arts and crafts media are included in occupational therapy curricula, they are strongly linked to psychosocial goals and treatment. Barris, Cordero, and Christiaansen (1986) finally concluded that while education did contribute to the way therapists practice, clinical training may be even more critical. Because clinical education did not always correspond to classroom education, the issue of how different facets of education interact to shape practice was worthy of attention and research.

As a result of a questionnaire to a random sample of 250 occupational therapists, it appeared that while therapists used crafts to some degree in their therapy programs, other treatment modalities such as therapeutic exercise and ADL "were used a greater percentage of the time" (Bissell & Mailloux 1981). Reasons for using crafts, problems with justification of craft use and participation of Certified Occupational Therapy Assistant's in craft programs were also discussed. Results on 141 therapists included in this study were as follows: 102 (72%) used crafts as part of their treatment plan to achieve therapeutic goals, whereas 39 (28%) did not. Fifty one percent of those respondents who stated that they used crafts further reported that craft use accounted for 20% or less of the total occupational therapy time. The results of the study reported that more than 63% of the therapists in practice stated that they did not encounter problems justifying the use of

crafts. However, of those who reported encountering problems (31%), the difficulty was mostly in justifying craft use to their patients and to themselves.

The predominant reasons therapists reported for not using crafts as part of their treatment programs included a preference for treatment techniques that lent themselves to more precise documentation, difficulty in justifying the therapeutic use of crafts, and difficulty in documenting the use of crafts. Priorities of treatment goals were also indicated by the findings in that whether or not crafts were used, the greatest percentage of treatment time was devoted to therapeutic exercise and self-care activities. When crafts were used, the most important reasons for incorporating them into the treatment program were to increase fine motor coordination, strength and endurance and improve cognitive and perceptual ability. In addition, a small percentage of treatment time was devoted to home skills, role performance skills and prevocational training. Overall, the occupational therapists surveyed seemed to stress the physical aspects of therapy with less emphasis on the psychological and social domains of treatment. The authors suggested that the lack of confidence in the use of crafts came from within the profession. This indicated two areas of need: 1) research which addressed not only the types of treatments which were most effective in facilitating muscle strength and coordination, but also those modalities which were most useful in enhancing patient adjustment to disability and adaptation to life role; and 2) research on craft use in different areas of occupational therapy practice to determine the role of craft use in the

treatment of other disability groups. As indicated by Bissell and Mailloux (1981), "If therapeutic crafts are no longer considered a central concept of occupational therapy practice there may be a need to revise the curricula pertaining to craft use" (p.374).

Fox (1991a), in an article describing the use of craft activities and perspective on the use of crafts in occupational therapy, described a program developed by Breines. Dr. Breines, as reported by Fox (1991a), does not believe that the occupational therapist should wholly embrace or summarily reject the use of crafts in their profession. "I don't think you can say yes to crafts or no to crafts. Crafts are among the main tools that we have" (Fox, 1991a). Breines designed an occupational therapy skills course at New York University in 1986. Breines teaches students early about the profession's foundation in crafts to address an image problem that crafts sometime have with new students, other disciplines and sometimes practicing therapists themselves. Breines believes that occupational therapists should be prepared to use a wide range of activities from crafts to computers. That way "when they encounter a patient for whom any of these activities is meaningful, they have a repertoire from which to draw. They must have enough exposure and enough grasp of what activities demand in terms of endeavor, concentration and strength to be able to draw upon them and offer them to their patients. They have to meet the patient where the patient is" (Fox 1991b).

Taylor and Manguno (1991) conducted their study using two samples of clinicians. The study surveyed 83 fieldwork supervisors and 59 former Louisiana State

University Medical Center students for the occupational therapy program in the south eastern region of the country. The questionnaire asked the respondent to identify how frequently their clinics had used each of the 67 listed treatment activities. The number of returns for the study of the 126 questionnaire sent to fieldwork supervisors was 86; of the 101 questionnaires mailed to former occupational therapy students, 60 were returned. The study demonstrated that non-craft activities were ranked as being used more frequently than major or minor craft activities in all settings and in all specialty areas of practice. Occupational therapists in all areas of practice ranked ADL/ self-care and social skills activities among the top five positions of activities frequently used in practice. Therapists in physical dysfunction areas of practice used crafts less frequently than those in psycho-social dysfunction areas of practice. The orders of treatment activities used in physical disability and psycho-social disability areas have different ranks. Physical disabilities responses were joint protection/ homemaking, self care, work simplification/ pre-vocational skills, relaxation/ sensory integration, and social skills. Psycho-social disabilities responses were social skills/ self care, games, leather stamping, woodworking (by hand), copper tooling, sensory integration, leather kits, community reorientation, homemaking, painting, and mosaics.

In comparing clinic and classroom education, Taylor and Manguno (1991) confirmed a disparity between what is taught in O.T. curricula and what is actually practiced in the clinic in the area of crafts. The survey revealed that craft usage is on the

decline except in the psychosocial area. Respondents also commented that crafts are more acceptable in some settings than others. As a result of this study time spent on activity analysis and the relationship between treatment activities and occupational performance across the life span was increased in the curriculum to enhance the students understanding and use of purposeful activities. The authors of this study suggested that a national survey using random sampling be conducted on a regular basis to maintain a current view of the use of treatment activities.

Fox (1991b) cited a study by Dickerson and Kaplan which demonstrated that crafts have decreased in use. They stated that, "There are very few crafts used daily or frequently in over 50% of the clinics, and very few specific crafts being used" (p.9). This study identified the types and numbers of crafts used in 384 psychosocial clinics and compared those results to the craft training received by students in 121 out of 139 accredited and developing occupational therapy programs. The survey revealed large discrepancies between craft training and usage. The results demonstrated that therapists trained in the use of crafts reported that crafts were not being used as often as was specified in their training. In addition, these therapists commented that life skill groups were replacing crafts which appear to have greater professional credibility (Fox, 1991b).

Summary

The studies in this literature review would best be summarized by comparing the results of the physical and psychosocial areas of practice as reported by the authors of these studies.

Studies related to the psychosocial disabilities area of practice described use of craft/art activities, games and work as being used frequently in comparison to the physical disabilities area of practice. The studies further described new treatment techniques related to biofeedback and new areas of possible growth in employee assistance programs, boarding homes and community centers. Occupational therapists who were surveyed responded by reporting that in addition to leading craft or hobby groups, they were also leading social skills groups, task skills groups and leisure groups. The tendency to use more traditional forms of treatments was more pronounced in the psychosocial area of practice than in the physical disabilities area.

Studies related to the physical disabilities area of practice described many changes from traditional forms of treatment. The studies reported that occupational therapists appeared to focus their treatment on daily living activities (ADL) and physical modalities, such as therapeutic exercise, sensory integration and facilitation/ inhibition techniques. It was suggested in the studies that physical disability therapists stress the physical aspects of therapy with less emphasis on the psychological or social domain of

treatment. Occupational therapists ranked joint protection/ homemaking, self-care, work simplification/ prevocational skills, relaxation, sensory integration, social skills, exercise and facilitation/inhibition techniques as most frequently used treatments.

Studies for both psychosocial and physical disabilities areas of practice ranked self-care and social skills activities among the most frequently used of activities in practice.

Chapter 3

RESEARCH PROCEDURE, DATA ANALYSIS, AND RESULTS

This was a retrospective study in which data from a previously conducted survey were analyzed to answer the following questions:

1. What are the adjunctive methods, performance skills, and leisure and pre-vocational activities used most frequently, occasionally, and seldom/never by occupational therapists whose primary practice is physical dysfunction?
2. What are the adjunctive methods, performance skills, and leisure and pre-vocational activities used most frequently, occasionally, and seldom/never by occupational therapists whose primary practice is psychosocial dysfunction?
3. What are the similarities among the adjunctive methods, performance skills, and leisure and pre-vocational activities used in occupational therapy practice for physical and psychosocial disabilities?

Procedure

The original survey was conducted in 1988. Two hundred questionnaires were mailed to occupational therapists who are clinical educators affiliated with San Jose State University. One hundred and forty-one questionnaires were returned for a response rate of 70 percent.

The questionnaire (See Appendix A) was developed by Carolyn Glogoski-Williams, M.S., OTR and Lorraine Pedretti, M.S., OTR as a members of the Curriculum Committee of the Department of Occupational Therapy at San Jose State University and distributed by Roberta K. Eyler, M.Ed., OTR (See Appendix B). The questionnaire was formulated to identify the adjunctive methods, performance skills and leisure and prevocational activities in use by occupational therapists (see Appendix B). The survey was conducted in fieldwork sites which were accepting San Jose State University students for their psychosocial or physical disabilities internships.

The questionnaire was divided into two sections. The general information classified the area in which the therapist worked (Psychiatry and Mental Health, Physical Disabilities or Developmental Disabilities), the type of practice in which the respondent was engaged and the age group of patients/ clients seen in practice. The second section was composed of title headings followed by treatment items which corresponded to the appropriate heading of adjunctive methods, enabling activities, performance skills, leisure and prevocational activities, computer, video skills, and work evaluation/hardening. The questionnaire provided spaces next to each treatment item to indicate how often the treatment was used in therapy: usually (75% or more), frequently (50-74%), occasionally (25-49%), seldom (24% or less) and never. There were 173 treatment items.

Data Analysis and Presentation of Data

The survey data were described according to the frequency with which adjunctive methods, performance skills, and leisure and pre-vocational activities were used by occupational therapists within the areas of psychosocial and physical disabilities. The response to type of therapy practiced the general information section of the survey was used to classify the respondents into two groups: psychiatry and mental health respondents were labeled “psychosocial” practitioners (N=58), while those who worked with physical or developmental disabilities were combined as “physical disabilities” practitioners (N=72). The responses to all 173 treatment items by these two groups were used to answer the research questions. The frequency distributions for each group are presented in Tables 1-6; note that percentages add to 100% in each row. Response categories of “usually” and “frequently” were combined, as were the categories of “seldom” and “never” for clarity in data presentation. Responses are presented in rank order of use frequency by the “physical disabilities” group in Tables 1-3, by the “psychosocial disabilities” group in Tables 4-6.

Table 1
 Physical Disabilities: Adjunctive Methods Identified by Occupational Therapist
 Ranked Usually/Frequently to Seldom/Never ($n = 72$)

Adjunctive Methods	Usually/ Frequently 50-100%	Occasionally 25-49%	Seldom/ Never 24-0%	No Response
Therapeutic exercise	64 (89%)	4 (5%)	3 (4%)	1 (1%)
Bobath approach	57 (79%)	10 (14%)	5 (7%)	0 (0%)
Splinting	54 (75%)	11 (15%)	7 (10%)	0 (0%)
Facilitation-Inhibition Technique	42 (58%)	5 (7%)	6 (8%)	19 (26%)
Oral motor evaluation	23 (46%)	12 (17%)	26 (36%)	1 (1%)
Massage	31 (43%)	7 (10%)	32 (44%)	2 (3%)
Oral motor facilitation/ inhibition	28 (39%)	15 (21%)	27 (37%)	2 (3%)
Vibration	26 (36%)	22 (31%)	23 (32%)	1 (1%)
Sensory arousal techniques	21 (29%)	24 (33%)	23 (32%)	4 (5%)
Relaxation techniques	19 (26%)	26 (36%)	27 (37%)	0 (0%)
PNF approach	18 (25%)	23 (32%)	28 (39%)	3 (4%)
Rood approach	13 (18%)	19 (26%)	35 (49%)	5 (7%)
Paraffin	13 (18%)	16 (22%)	42 (58%)	1 (1%)
Brunnstrom approach	10 (14%)	20 (28%)	38 (53%)	4 (5%)
Icing	10 (14%)	22 (31%)	40 (56%)	0 (0%)
Hot packs	10 (14%)	12 (17%)	48 (67%)	2 (3%)
TENS	9 (12%)	2 (3%)	61 (85%)	0 (0%)
Brushing	8 (11%)	7 (10%)	53 (74%)	4 (6%)
Functional Electrical Stimulation	7 (10%)	12 (17%)	51 (71%)	2 (3%)
Ayres S.I. approach	4 (5%)	13 (18%)	52 (72%)	3 (4%)
Biofeedback	4 (5%)	9 (12%)	57 (79%)	2 (3%)
Whirlpool	3 (4%)	8 (11%)	59 (82%)	2 (3%)

Table 2

Physical Disabilities: Performance Skills Identified by Occupational Therapist Ranked Usually/Frequently to Seldom/Never (n = 72)

Performance Skills	Usually/ Frequently 50-100%	Occasionally 25-49%	Seldom/ Never 24-0%	No Response
ADL: Dressing	68 (94%)	2 (3%)	2 (3%)	0 (0%)
ADL: Hygiene	66 (92%)	3 (4%)	3 (4%)	0 (0%)
ADL: Grooming	66 (92%)	3 (4%)	3 (4%)	0 (0%)
ADL: Management of environment	63 (87%)	6 (8%)	2 (3%)	1 (1%)
Adaptive equipment: acquisition	61 (85%)	6 (8%)	2 (3%)	3 (4%)
ADL: Feeding training	61 (85%)	4 (5%)	7 (10%)	0 (0%)
Home/community living: Home and personal safety	60 (83%)	9 (12%)	3 (4%)	0 (0%)
Adaptive equipment: training	60 (83%)	4 (5%)	1 (1%)	7 (10%)
Meal preparation and planning	59 (82%)	8 (11%)	5 (7%)	0 (0%)
Adaptive equipment	55 (76%)	6 (8%)	1 (1%)	10 (14%)
Transfer skills	52 (72%)	12 (17%)	8 (11%)	0 (0%)
Table top perceptual exercise	50 (69%)	13 (18%)	8 (11%)	1 (1%)
Writing skills	47 (65%)	21 (29%)	4 (5%)	0 (0%)
Work simplification technique	45 (62%)	21 (29%)	3 (4%)	3 (4%)
Energy conservation technique	44 (61%)	24 (33%)	3 (4%)	1 (1%)
Money management	40 (55%)	14 (19%)	17 (24%)	1 (1%)
Telephone usage	39 (54%)	19 (26%)	14 (19%)	0 (0%)
Stacking cones, blocks	38 (53%)	17 (24%)	16 (22%)	1 (1%)
Computers for: Cognitive retraining	34 (47%)	20 (28%)	16 (22%)	2 (3%)
Mobility training: Community transportation	33 (46%)	16 (22%)	22 (30%)	1 (1%)

Continued...

Table 2
Physical Disabilities: Performance Skills (continued)

Performance Skill	Usually/ Frequently 50-100%	Occasionally 25-49%	Seldom/ Never 24-0%	No Response
Adaptive equipment: manufacture	32 (44%)	21 (25%)	15 (21%)	4 (5%)
Mobility training: Wheelchair management	32 (44%)	17 (24%)	23 (32%)	0 (0%)
Shopping	32 (44%)	16 (22%)	23 (32%)	1 (1%)
Skateboard	31 (43%)	21 (29%)	18 (25%)	2 (3%)
Laundry, ironing, clothing care	27 (37%)	24 (33%)	19 (26%)	2 (3%)
Communication skills: Computer operation	26 (36%)	22 (30%)	22 (30%)	1 (1%)
Time management: Interpersonal/ social interaction	26 (36%)	22 (30%)	22 (30%)	2 (3%)
Typing skills	25 (35%)	24 (33%)	22 (30%)	1 (1%)
House cleaning	25 (35%)	24 (33%)	22 (30%)	1 (1%)
Dressing practice boards	24 (33%)	23 (32%)	23 (32%)	2 (3%)
Wheelchair selection	24 (33%)	9 (12%)	38 (53%)	1 (1%)
Work simulators	22 (30%)	18 (25%)	28 (39%)	4 (5%)
Wheelchair measurement	21 (29%)	9 (12%)	41 (57%)	1 (1%)
Sanding board	20 (28%)	20 (28%)	29 (40%)	3 (4%)
Time management	18 (25%)	21 (29%)	23 (32%)	10 (14%)
Hardware practice boards	17 (24%)	20 (28%)	31 (43%)	4 (5%)
Group process: Leading group activities	16 (22%)	18 (25%)	37 (51%)	1 (1%)
Driver evaluation	15 (21%)	7 (10%)	44 (61%)	6 (8%)
Leisure planning	15 (21%)	25 (35%)	29 (40%)	3 (4%)

Continued...

Table 2
Physical Disabilities: Performance Skills (continued)

Performance Skills	Usually/ Frequently 50-100%	Occasionally 25-49%	Seldom/ Never 24-0%	No Response
Environmental control systems	12 (17%)	13 (18%)	46 (64%)	1 (1%)
Tape recorder	11 (15%)	17 (24%)	43 (60%)	1 (1%)
Group process:				
Discussion groups	10 (14%)	12 (17%)	49 (68%)	1 (1%)
Driver training	8 (11%)	6 (8%)	3 (74%)	5 (7%)
Child care	7 (10%)	17 (24%)	46 (64%)	2 (3%)
Group process	6 (8%)	12 (17%)	44 (61%)	10 (14%)
Group process: role playing and role reversal	1 (1%)	6 (8%)	58 (80%)	7 (10%)

Table 3
Physical Disabilities: Leisure and Pre-Vocational Activities Identified by
Occupational Therapist Ranked Usually/Frequently to Seldom/Never (n = 72)

Leisure and Pre-Vocational Activities	Usually/ Frequently 50-100%	Occasionally 25-49%	Seldom/ Never 24-0%	No Response
Games: non-competitive physical games	19 (26%)	28 (39%)	24 (33%)	1 (1%)
Wood kits	17 (24%)	19 (26%)	33 (46%)	3 (4%)
Woodwork: Hand tools (construction of small objects)	13 (18%)	22 (30%)	35 (49%)	2 (3%)
Games: Competitive table games	11 (15%)	25 (35%)	34 (47%)	2 (3%)
Games: Competitive physical games	10 (14%)	16 (22%)	44 (61%)	2 (3%)
Leatherwork: kits	8 (11%)	16 (22%)	46 (64%)	2 (3%)
Leatherwork: lacing (3%)	5 (7%)	18 (25%)	47 (65%)	2
Ceramic decorating	5 (7%)	9 (12%)	56 (78%)	2 (3%)
Ceramics/pottery	4 (5%)	5 (7%)	50 (69%)	13 (18%)
Tile mosaics	4 (5%)	20 (28%)	46 (64%)	2 (3%)
Copper tooling	4 (5%)	13 (18%)	52 (72%)	3 (4%)
Macrame	4 (5%)	15 (21%)	49 (68%)	4 (5%)
Leatherwork: stamping	4 (5%)	12 (17%)	54 (75%)	2 (3%)
Leatherwork: tooling	4 (5%)	9 (12%)	57 (79%)	2 (3%)
Decoupage	3 (4%)	7 (10%)	60 (83%)	2 (3%)
Water color	2 (3%)	3 (4%)	65 (90%)	2 (3%)
Paper crafts: collage	2 (3%)	2 (3%)	65 (90%)	3 (4%)
Machine working: jigsaw	2 (3%)	11 (15%)	58 (80%)	1 (1%)

Table 3
Physical Disabilities: Leisure and Pre-Vocational Activities (continued)

Leisure and Pre-Vocational Activities	Usually/ Frequently 50-100%	Occasionally 25-49%	Seldom/ Never 24-0%	No Response
Plastic crafts	2 (3%)	6 (8%)	61 (85%)	3 (4%)
Machine woodworking: band saw	2 (3%)	6 (8%)	62 (86%)	2 (3%)
Hand sewing	1 (1%)	8 (11%)	61 (85%)	2 (3%)
Knitting	1 (1%)	7 (10%)	62 (86%)	2 (3%)
Machine woodworking: table saw	1 (1%)	5 (7%)	64 (89%)	2 (3%)
Machine woodworking: planer	1 (1%)	5 (7%)	64 (89%)	2 (3%)
Ceramics/pottery: hand modeling	1 (1%)	3 (4%)	64 (89%)	4 (5%)
Basketry	1 (1%)	3 (4%)	65 (90%)	3 (4%)
Copper molding (bowls/ashtrays)	1 (1%)	3 (4%)	66 (92%)	3 (4%)
Needlepoint	0 (0%)	8 (11%)	62 (86%)	2 (3%)
Clothing construction/ machine sewing	0 (0%)	7 (10%)	63 (87%)	2 (3%)
Crocheting	0 (0%)	6 (8%)	64 (89%)	2 (3%)
Turkish knotting	0 (0%)	6 (8%)	63 (87%)	3 (4%)
Embroidery	0 (0%)	5 (7%)	65 (90%)	2 (3%)
Table loom weaving	0 (0%)	5 (7%)	64 (89%)	3 (4%)
Origami	0 (0%)	5 (7%)	64 (89%)	3 (4%)
Stained glass	0 (0%)	5 (7%)	64 (89%)	3 (4%)
Braid weaving	0 (0%)	4 (5%)	65 (90%)	3 (4%)
Tatting	0 (0%)	4 (5%)	66 (92%)	2 (3%)
Construction paper objects	0 (0%)	4 (5%)	65 (90%)	3 (4%)

Continued...

Table 3
Physical Disabilities: Leisure and Pre-Vocational Activities (continued)

Leisure and Pre-Vocational Activities	Usually/ Frequently 50-100%		Occasionally 25-49%		Seldom/ Never 24-0%		No Response	
Pencil sketching	0	(0%)	3	(4%)	66	(92%)	3	(4%)
Block printing	0	(0%)	3	(4%)	68	(94%)	1	(1%)
Finger painting	0	(0%)	3	(4%)	67	(93%)	2	(3%)
Printing	0	(0%)	3	(4%)	66	(92%)	3	(4%)
Stamping	0	(0%)	4	(5%)	67	(93%)	1	(1%)
Tempera/acrylics	0	(0%)	2	(3%)	68	(94%)	3	(4%)
Sculpting	0	(0%)	2	(3%)	68	(94%)	2	(3%)
Pastel sketching	0	(0%)	2	(3%)	67	(93%)	3	(4%)
Charcoal sketching	0	(0%)	2	(3%)	67	(93%)	3	(4%)
Floor loom weaving	0	(0%)	2	(3%)	67	(93%)	3	(4%)
Hairpin crochet	0	(0%)	2	(3%)	67	(93%)	3	(4%)
Paper mache	0	(0%)	2	(3%)	67	(93%)	3	(4%)
Copper enameling	0	(0%)	2	(3%)	68	(94%)	2	(3%)
Jewelry making	0	(0%)	2	(3%)	69	(96%)	1	(1%)
Card weaving	0	(0%)	1	(1%)	68	(94%)	3	(4%)
Fabric decoration with paints	0	(0%)	1	(1%)	69	(96%)	2	(3%)
Fabric stenciling	0	(0%)	1	(1%)	69	(96%)	2	(3%)
Potter's wheel	0	(0%)	1	(1%)	69	(96%)	2	(3%)
Silk screening	0	(0%)	1	(1%)	70	(97%)	1	(1%)
Tie dyeing	0	(0%)	1	(1%)	69	(96%)	2	(3%)
Oil painting	0	(0%)	0	(0%)	68	(94%)	4	(5%)
Batik	0	(0%)	0	(0%)	70	(97%)	2	(3%)
Potato printing	0	(0%)	0	(0%)	71	(99%)	1	(1%)
Letterpress printing (printing press)	0	(0%)	0	(0%)	71	(99%)	1	(1%)

Table 4
 Psychosocial Disabilities: Adjunctive Methods Identified by Occupational Therapist
 Ranked Usually/Frequently to Seldom/Never ($n = 58$)

Adjunctive Methods	Usually/ Frequently 50-100%	Occasionally 25-49%	Seldom/ Never 24-0%	No Response
Relaxation techniques	19 (33%)	19 (33%)	16 (27%)	4 (7%)
Therapeutic exercise	17 (29%)	7 (12%)	28 (48%)	6 (10%)
Sensory arousal techniques	8 (14%)	8 (14%)	35 (60%)	7 (12%)
Ayres S.I. Approach	5 (9%)	5 (9%)	41 (71%)	7 (12%)
Splinting	1 (2%)	0 (0%)	48 (83%)	9 (15%)
Facilitation/Inhibition technique	1 (2%)	0 (0%)	47 (81%)	10 (17%)
Biofeedback	0 (0%)	2 (3%)	47 (81%)	9 (15%)
Massage	0 (0%)	1 (2%)	48 (83%)	9 (15%)
Oral motor evaluation	0 (0%)	1 (2%)	48 (83%)	9 (15%)
Oral motor facilitation/ inhibition	0 (0%)	1 (2%)	48 (83%)	9 (15%)
Vibration	0 (0%)	0 (0%)	50 (86%)	8 (14%)
Bobath approach	0 (0%)	0 (0%)	49 (84%)	9 (15%)
Brushing	0 (0%)	0 (0%)	50 (86%)	8 (14%)
Rood approach	0 (0%)	0 (0%)	49 (84%)	9 (15%)
Brunnstrom approach	0 (0%)	0 (0%)	49 (84%)	9 (15%)
Whirlpool	0 (0%)	1 (2%)	48 (83%)	9 (15%)
PNF approach	0 (0%)	0 (0%)	48 (83%)	10 (17%)
Hot packs	0 (0%)	0 (0%)	49 (84%)	9 (15%)
Parafin	0 (0%)	0 (0%)	49 (84%)	9 (15%)
TENS	0 (0%)	0 (0%)	49 (84%)	9 (15%)
Icing	0 (0%)	0 (0%)	50 (86%)	8 (14%)
Functional Electrical Stimulation	0 (0%)	0 (0%)	49 (84%)	9 (15%)

Table 5
 Psychosocial Disabilities: Performance Skills Identified by Occupational Therapist
 Ranked Usually/Frequently to Seldom/Never ($n = 58$)

Performance Skills	Usually/ Frequently 50-100%	Occasionally 25-49%	Seldom/ Never 24-0%	No Response
Time management: Interpersonal/ social interaction	55 (95%)	2 (3%)	0 (0%)	1 (2%)
Time management:				
Leisure planning	54 (93%)	0 (0%)	2 (3%)	2 (3%)
Leading group activities	53 (91%)	3 (5%)	1 (2%)	1 (2%)
Discussion groups	50 (86%)	4 (7%)	2 (3%)	2 (3%)
Time management	42 (72%)	3 (5%)	1 (2%)	12 (21%)
Group process	36 (62%)	6 (10%)	2 (3%)	14 (24%)
Meal preparation and planning	35 (60%)	13 (22%)	10 (17%)	0 (0%)
Group Process: Role playing and role rehearsal	34 (59%)	12 (21%)	6 (10%)	6 (10%)
Money management	27 (46%)	21 (36%)	8 (14%)	2 (3%)
ADL: Grooming	26 (45%)	17 (29%)	12 (21%)	3 (5%)
Shopping	26 (45%)	13 (22%)	17 (29%)	3 (5%)
Home/community living:				
Home and personal safety	24 (41%)	16 (27%)	12 (21%)	6 (10%)
ADL: Hygiene	24 (41%)	19 (33%)	12 (21%)	3 (5%)
ADL: Management of environment	19 (33%)	12 (21%)	20 (34%)	7 (12%)
Laundry/ironing/clothing care	17 (29%)	18 (31%)	20 (34%)	3 (5%)
House cleaning	16 (27%)	12 (21%)	25 (43%)	5 (9%)
Writing	14 (24%)	14 (24%)	23 (40%)	7 (12%)
Telephone usage	14 (24%)	9 (15%)	30 (52%)	5 (9%)
ADL: Dressing	9 (15%)	9 (15%)	34 (59%)	6 (10%)

Continued...

Table 5
 Psychosocial Disabilities: Performance Skills (continued)

Performance Skills	Usually/ Frequently 50-100%		Occasionally 25-49%		Seldom/ Never 24-0%		No Response	
Child care	9	(15%)	8	(14%)	36	(62%)	5	(9%)
Mobility training:								
Community transportation	6	(10%)	10	(17%)	34	(59%)	8	(14%)
Typing	6	(10%)	10	(17%)	36	(62%)	6	(10%)
Work simplification technique	5	(9%)	11	(19%)	31	(53%)	11	(19%)
Energy conservation technique	5	(9%)	9	(15%)	34	(59%)	10	(17%)
Computers for: Cognitive retraining	4	(7%)	7	(12%)	39	(67%)	8	(14%)
Communication skills:								
Computer operation	3	(5%)	8	(14%)	40	(69%)	7	(12%)
Tape recorder	3	(5%)	5	(9%)	43	(74%)	7	(12%)
Table top perceptual exercise	3	(5%)	3	(5%)	43	(74%)	9	(15%)
Work simulators	2	(3%)	5	(9%)	41	(71%)	10	(17%)
ADL: Feeding training	2	(3%)	4	(7%)	43	(74%)	9	(15%)
Adaptive equipment:								
training	2	(3%)	2	(3%)	44	(76%)	10	(17%)
Adaptive equipment	2	(3%)	1	(2%)	42	(72%)	13	(22%)
Adaptive equipment:								
acquisition	1	(2%)	2	(3%)	45	(77%)	10	(17%)
Sanding board	1	(2%)	2	(3%)	46	(79%)	9	(15%)
Stacking cones, blocks	1	(2%)	2	(3%)	46	(79%)	9	(15%)
Environmental control systems	0	(0%)	4	(7%)	43	(74%)	11	(19%)
Skateboard	0	(0%)	1	(2%)	48	(83%)	9	(15%)
Hardware practice boards	0	(0%)	1	(2%)	47	(81%)	10	(17%)
Transfer skills	0	(0%)	1	(2%)	49	(84%)	8	(14%)

Table 5
 Psychosocial Disabilities: Performance Skills (continued)

Performance Skills	Usually/ Frequently 50-100%	Occasionally 25-49%	Seldom/ Never 24-0%	No Response
Mobility training:				
Wheelchair management	0 (0%)	1 (2%)	50 (86%)	7 (12%)
Wheelchair selection	0 (0%)	1 (2%)	48 (83%)	9 (15%)
Wheelchair measurement	0 (0%)	1 (2%)	48 (83%)	9 (15%)
Driver evaluation	0 (0%)	1 (2%)	48 (83%)	9 (15%)
Driver training	0 (0%)	1 (2%)	49 (84%)	8 (14%)
Adaptive equipment:				
manufacture	0 (0%)	0 (0%)	47 (81%)	11 (19%)
Dressing practice boards				
	0 (0%)	0 (0%)	48 (83%)	10 (17%)

Table 6
 Psychosocial Disabilities: Leisure and Pre-Vocational Activities Identified by
 Occupational Therapist Ranked Usually/Frequently to Seldom/Never (n = 58)

Leisure and Pre-Vocational Activities	Usually/ Frequently 50-100%		Occasionally 25-49%		Seldom/ Never 24-0%		No Response	
	38 (65%)	7 (12%)	11 (19%)	2				
Leatherwork: lacing (3%)								
Non-competitive physical games	36 (62%)	14 (24%)	5 (9%)	3 (5%)				
Collage	36 (62%)	12 (21%)	8 (14%)	2 (3%)				
Leatherwork: kits	37 (64%)	9 (15%)	11 (19%)	1 (2%)				
Tile mosaics	35 (60%)	7 (12%)	14 (24%)	2 (3%)				
Wood kits	34 (59%)	12 (21%)	11 (19%)	1 (2%)				
Leatherwork: stamping	33 (57%)	10 (17%)	13 (22%)	2 (3%)				
Decoupage	31 (53%)	15 (26%)	9 (15%)	3 (5%)				
Competitive table games	31 (53%)	16 (27%)	10 (17%)	1 (2%)				
Copper tooling	30 (52%)	15 (26%)	11 (19%)	2 (3%)				
Ceramic decorating	30 (52%)	12 (21%)	15 (26%)	1 (2%)				
Water color	29 (50%)	18 (31%)	10 (17%)	1 (2%)				
Ceramics/pottery	27 (46%)	7 (12%)	10 (17%)	14 (24%)				
Hand tools (construction of small objects)	27 (46%)	12 (21%)	17 (29%)	2 (3%)				
Competitive physical games	25 (43%)	14 (24%)	15 (26%)	4 (7%)				
Tempera/acrylics	25 (43%)	19 (33%)	13 (22%)	1 (2%)				
Tooling	24 (41%)	13 (22%)	18 (31%)	3 (5%)				
Pencil sketching	24 (41%)	14 (24%)	19 (33%)	1 (2%)				
Hand modeling	23 (40%)	14 (24%)	20 (34%)	1 (2%)				
Pastel sketching	21 (36%)	14 (24%)	22 (38%)	1 (2%)				
Hand sewing	19 (33%)	21 (36%)	17 (29%)	1 (2%)				
Plastic crafts	17 (29%)	13 (22%)	24 (41%)	4 (7%)				
Construction of paper objects	15 (26%)	20 (34%)	21 (36%)	2 (3%)				

Table 6
 Psychosocial Disabilities: Leisure and Pre-Vocational Activities (continued)

Leisure and Pre-Vocational Activities	Usually/ Frequently 50-100%		Occasionally 25-49%		Seldom/ Never 24-0%		No Response	
Charcoal sketching	15	(26%)	15	(26%)	27	(46%)	1	(2%)
Embroidery	14	(24%)	2	(3%)	21	(36%)	15	(26%)
Sculpting	14	(24%)	14	(24%)	28	(48%)	2	(3%)
Jewelry making	13	(22%)	10	(17%)	29	(50%)	6	(10%)
Needlepoint	13	(22%)	22	(38%)	22	(38%)	14	(24%)
Stained glass	12	(21%)	4	(7%)	36	(62%)	6	(10%)
Fabric decoration with paints	12	(21%)	19	(33%)	24	(41%)	3	(5%)
Fabric stenciling	12	(21%)	19	(33%)	24	(41%)	3	(5%)
Finger painting	11	(19%)	19	(33%)	26	(45%)	2	(3%)
Knitting	9	(15%)	24	(41%)	25	(43%)	0	(0%)
Copper enameling	9	(15%)	10	(17%)	35	(60%)	4	(7%)
Basketry	9	(15%)	9	(15%)	35	(60%)	5	(9%)
Crocheting	9	(15%)	25	(43%)	24	(41%)	0	(0%)
Macrame	8	(14%)	18	(31%)	31	(53%)	1	(2%)
Oil painting	8	(14%)	8	(14%)	39	(67%)	3	(5%)
Stamping (rubber stamps)	7	(12%)	11	(19%)	37	(64%)	3	(5%)
Jigsaw	7	(12%)	4	(7%)	44	(76%)	3	(5%)
Origami	6	(10%)	15	(26%)	32	(55%)	5	(9%)
Paper mache	6	(10%)	14	(24%)	36	(62%)	2	(3%)
Printing	5	(9%)	13	(22%)	35	(60%)	5	(9%)
Potter's wheel	5	(9%)	4	(7%)	45	(77%)	4	(7%)
Band saw	5	(9%)	0	(0%)	50	(86%)	3	(5%)
Clothing construction and machine sewing	4	(7%)	8	(14%)	43	(74%)	3	(5%)
Block printing	4	(7%)	13	(22%)	39	(67%)	2	(3%)
Tie Dying	4	(7%)	9	(15%)	43	(74%)	2	(3%)

Continued...

Table 6
 Psychosocial Disabilities: Leisure and Pre-Vocational Activities (continued)

Leisure and Pre-Vocational Activities	Usually/ Frequently 50-100%		Occasionally 25-49%		Seldom/ Never 24-0%		No Response	
Braid weaving	3	(5%)	4	(7%)	44	(76%)	7	(12%)
Table saw	3	(5%)	1	(2%)	50	(86%)	4	(7%)
Potato printing	2	(3%)	8	(14%)	46	(79%)	2	(3%)
Tattling	2	(3%)	5	(9%)	47	(81%)	6	(10%)
Turkish knotting	2	(3%)	1	(2%)	48	(83%)	7	(12%)
Silk screening	1	(2%)	4	(7%)	49	(84%)	4	(7%)
Copper molding								
(blows/ashtrays)	1	(2%)	3	(5%)	50	(86%)	4	(7%)
Table loom weaving	1	(2%)	2	(3%)	50	(86%)	5	(9%)
Hairpin crochet	1	(2%)	1	(2%)	56	(96%)	0	(0%)
Planer	1	(2%)	1	(2%)	51	(89%)	5	(9%)
Batik	0	(0%)	7	(12%)	47	(81%)	4	(7%)
Floor loom weaving	0	(0%)	7	(12%)	47	(81%)	4	(7%)
Card weaving	0	(0%)	1	(2%)	51	(89%)	6	(10%)
Letterpress printing	0	(0%)	1	(2%)	52	(90%)	5	(9%)

Results

The research questions can be answered as follows:

1. What are the adjunctive methods, performance skills, and leisure and pre-vocational activities used most frequently, occasionally, and seldom/never by occupational therapists whose primary practice is physical dysfunction?

The adjunctive methods used most frequently by a majority of respondents in physical dysfunction practice are therapeutic exercise, Bobath approach, splinting, and facilitation/inhibition techniques. The most frequently used performance skills were ADL: dressing, hygiene, grooming, management of environment, adaptive equipment: acquisition, feeding training, home/personal safety, meal preparation and planning, adaptive equipment, transfer training, table top perceptual exercise, writing, work simplification techniques, energy conservation techniques, money management, telephone usage, and stacking. There were no leisure and pre-vocational activities which were used 50-100% of the time by a majority of respondents.

Adjunctive methods used occasionally were relaxation techniques, sensory arousal, PNF approach, vibration, icing, Brunnstrom approach, and Rood approach. Performance skills used occasionally were time management: leisure planning, laundry/ironing/ clothing care, house cleaning, typing, dressing practice board, time management: interpersonal and social interaction, computer skills: computer operation, time

management, adaptive equipment: manufacture, skateboard, sanding board, hardware practice board, work simulators, and leading group activities. Leisure and pre-vocational activities used occasionally were non-competitive physical games, competitive physical games, woodwork: hand tools (construction of small objects), tile mosaics, wood kits, and leatherwork: lacing. The remaining activities were seldom or never used by 50% or more therapists working in the area of physical dysfunction (See Tables 1-3).

2. What are the adjunctive methods, performance skills, and leisure and pre-vocational activities used most frequently, occasionally, and seldom/never by occupational therapists whose primary practice is psychosocial dysfunction?

There were no adjunctive methods identified as most frequently used by a majority of therapists in psychosocial dysfunction. The performance skills used usually/frequently were time management: interpersonal/social interaction, time management: leisure planning, group process: leading group activities, group process: discussion groups, time management, group process, meal preparation and planning, and group process: role playing/role rehearsal. The usually/frequently used leisure and pre-vocational activities were leatherwork: lacing, leatherwork: kits, non-competitive physical games, collage, tile mosaics, wood kits, leatherwork: stamping, competitive table games, decoupage, copper tooling, ceramic decorating, and watercolor.

The adjunctive method used occasionally by at least 25% of the psychosocial therapists is relaxation techniques. The performance skills used occasionally are money

management, hygiene, laundry/ ironing/ clothing care, grooming, and home/personal safety. The most occasionally used leisure and pre-vocational activities were crocheting, knitting, embroidery, needlepoint, hand sewing, construction of paper objects, tempera/acrylics, fingerpainting, fabric decoration with paints, fabric stenciling, macrame, charcoal sketching, and origami. The remaining activities were seldom or never used by 50% or more therapists working in the area of psychosocial dysfunction (see Tables 4-6).

3. What are the similarities among the adjunctive methods, performance skills, and leisure and pre-vocational activities used in occupational therapy practice for physical and psychosocial disabilities?

There were few similarities between adjunctive methods, performance skills, and leisure and pre-vocational activities in those frequently and occasionally used in psychosocial and physical disability areas of practice. However, there were more similarities in the items identified in the seldom/never used leisure and pre-vocational activities category. There were no usually/frequently used adjunctive methods identified by 50% or more therapists in both groups. The only similar performance skill used frequently by a majority of both groups was meal preparation and planning. There were no frequently used leisure and pre-vocational activities used frequently by a majority of physical disabilities therapists. Adjunctive methods used occasionally by both groups of therapists was relaxation techniques. The performance skills used occasionally were

physical disabilities therapists. Adjunctive methods used occasionally by both groups of therapists was relaxation techniques. The performance skills used occasionally were laundry/ ironing/clothing care and money management. Occasional use of leisure and pre-vocational activities had no group similarities. Adjunctive methods used seldom or never by 50% or more therapists in both groups included TENS, whirlpool, biofeedback, paraffin, Brunnstrom approach, icing, hot packs, brushing, functional electrical stimulation and Ayres S.I. approach. There were no similarities when comparing seldom/never used performance skills. Neither therapist group used the following leisure and pre-vocational activities: hairpin crochet, letterpress printing, card weaving, machine woodworking: planer, floor loom weaving, copper molding (bowls and ashtrays), machine woodworking: table saw, machine woodworking: bandsaw, silk screening, Turkish knotting, table loom weaving, batik, tatting, potato printing, potter's wheel, braid weaving, jewelry making, stained glass, copper enameling, basketry, macrame, oil painting, stamping (rubber stamps), origami, paper mache, printing, clothing construction and machine sewing, and tie dying.

Chapter 4

SUMMARY AND IMPLICATIONS

Occupational therapy has grown and changed over the years. It has become necessary to take an inventory of what is being used and what is not. This study was limited by its distribution to fieldwork sites affiliated with San Jose State University, thus the information may not be applicable to all Occupational Therapy educational institutions and clinics. However, the information may be useful for curriculum review at San Jose State University.

The results of this study, when compared with previous studies, identified similarities and differences regarding specific adjunctive methods, performance skills and leisure/prevocational activities. In dividing the areas of practice into physical and psychosocial disability areas, the results of this study can be shown to support previous studies that demonstrate that the tendency to use more traditional forms of treatment in the psychosocial area of practice. Although the review of the literature revealed that biofeedback was identified as a new treatment technique which was being incorporated into psychosocial disability practice, this study refuted the use of this modality as being used on a frequent or occasional basis. This study identified biofeedback to be used seldom/never by 81% of practicing therapists. This study supported previous results reporting occupational therapists' use of craft or hobby groups on a frequent or

occasional basis. The review of the literature identified social skills groups, task skills groups and leisure groups as new areas of growth in the psychosocial practice area (Barris, 1984; Kielhofner & Barris, 1984; Taylor & Manguno, 1991). This study supported these results which identified performance skills groups with emphasis on time management: interpersonal/social interaction and leisure planning; group process: leading group activities, discussion groups, and role playing/role rehearsal; meal planning and preparation. Previous studies identified new areas of possible growth in employee assistance programs, boarding homes and community centers (Bonder, 1987), whereas this study reported more specific treatments related to ADL/self-care, manners and nutritional education, communication for creative writing, geropsychiatry for mobility training and conestacking, and time management for stress management.

In comparing the results of this study for the physical disability area of practice, this study supported the results of previous studies which report the move away from traditional treatments with growth in the use of new treatment activities and techniques (Barris, Cordero & Christiaansen, 1986). The majority of previous studies identified the increased used of modalities/adjunctive methods which were being used frequently in occupational therapy practice (Barris, Cordero & Christiaansen, 1986). This study supported the results of these studies which identified frequent use of therapeutic exercise and facilitation/inhibition techniques. However, sensory integration and relaxation techniques were not identified as frequently used treatment in this study, as

they have been identified in previous studies. Bobath approach and splinting were identified as frequently used adjunctive methods. Previous studies identified performance skills related to ADL/self-care, joint protection/homemaking; work simplification/ prevocational skills and social skills as frequently used treatments (Taylor & Manguno, 1991).

This study provided strong evidence regarding increased used of performance skills. These results were congruent with a previous study that identified the frequent use of ADL/ self-care, and work simplification (Taylor & Manguno, 1991). The treatments not identified in this study as frequently used were joint protection/homemaking, prevocational skills, and social skills. In addition, this study identified management of environment, adaptive equipment, feeding training, meal planning and preparation, transfer training, table top perceptual exercises, writing, energy conservation techniques, money management and telephone usage as frequently used performance skills. In support of previous results, this study identified no leisure/prevocational activities used on a frequent basis.

Implications for Curriculum Review

The results of this study indicated that occupational therapists in both physical and psychosocial disability areas of practice use a wide variety of adjunctive methods, performance skills and leisure/prevocational activities. A curriculum providing a basic

introduction to these treatment areas, with an emphasis on frequently used items and giving declining priority to occasionally used items, and brief introduction to seldom/never used treatments, might best prepare students for the transition from classroom to practice. Emphasis could be placed on frequently used treatment activities identified by this study and progress to occasionally used treatments as the use of these activities/techniques may vary in clinical settings. Items which have been identified as seldom/never used such as adjunctive methods for the psychosocial areas of practice, and leisure/prevocational activities for the physical disability area might be excluded from the curriculum.

According to this study, the activities which would seem to be most critical to include in the curriculum in occupational therapy are therapeutic exercise, Bobath approach, splinting, facilitation/inhibition techniques, ADL: dressing, hygiene, grooming, management of environment, adaptive equipment: acquisition, feeding training, home/personal safety, meal preparation and planning, adaptive equipment, transfer training, table top perceptual exercise, writing, work simplification techniques, energy conservation techniques, money management and telephone usage in the physical disabilities area of practice. The activities which would seem to be most critical to include in the curriculum in occupational therapy in the psychosocial area of practice are time management: interpersonal/social interaction, time management: leisure planning, group process: discussion groups, time management, group process, meal preparation and

planning, group process: role playing/role rehearsal, leatherwork: lacing, leatherwork kits, non-competitive physical games, collage, tile mosaics, wood kits, leatherwork: stamping, competitive table games, decoupage, copper tooling, ceramic decorating and watercolor.

In the additional comment sections of the questionnaire, the following activities were identified for physical disability areas of practice: adjunctive methods related to upper extremity/hand therapy techniques; performance skills related to enabling activities, driving/predriving screening and evaluation, and computers related to perceptual, visual perceptual retraining, children/pediatrics, pre-vocational retraining and graphics; and leisure and prevocational activities related to latchworking, pour mold ceramics, power tools, jewelry making, ink painting and computers. For psychosocial disability areas of practice: performance skills related to geropsychiatry (cone stacking, mobility training) and ADL/ self-care (manners and nutritional education), communication skills (creative writing) and time management (stress management) were identified.

Education and clinical practice influence each other. By analyzing adjunctive methods, performance skill and leisure and pre-vocational activities educators, students and clinicians are able to identify usually/frequently used, occasionally used and seldom/never used items in order to more effectively prepare new students for their clinical practice.

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APPENDIX A
QUESTIONNAIRE

SAN JOSE STATE UNIVERSITY
Department of Occupational Therapy
 November 14, 1988

Survey of Methods, Activities, and Skills used in Occupational Therapy Practice.

I. GENERAL INFORMATION

A. Area (Check only one)

- Psychiatry & Mental Health _____ 1
- Physical Disabilities _____ 2
- Developmental Disabilities _____ 3

B. Type (Check as many as apply)

- Private Practice _____ 1
- Home Health _____ 2
- Inpatient _____ 3
- Outpatient _____ 4
- Hand Rehab _____ 5
- Day Treatment _____ 6
- School _____ 7

C. Age (Check only one)

- Infant/Child _____ 1
- Adolescent _____ 2
- Adults _____ 3
- Aged _____ 4

II. Listed below are methods, activities and skills used in the practice of occupational therapy. Please indicate your department's estimated frequency of use by checking the appropriate column.

<u>Adjunctive Methods</u>	Usually 75%	Frequently 74-50%	Occasionally 49-25%	Seldom 24-1%	Never 0%
Icing	_____ 1	_____ 2	_____ 3	_____ 4	_____ 5
Brushing	_____ 1	_____ 2	_____ 3	_____ 4	_____ 5
Vibration	_____ 1	_____ 2	_____ 3	_____ 4	_____ 5
Massage	_____ 1	_____ 2	_____ 3	_____ 4	_____ 5
Functional Electrical Stimulation.	_____ 1	_____ 2	_____ 3	_____ 4	_____ 5
Biofeedback	_____ 1	_____ 2	_____ 3	_____ 4	_____ 5
Hot packs	_____ 1	_____ 2	_____ 3	_____ 4	_____ 5
Whirlpool	_____ 1	_____ 2	_____ 3	_____ 4	_____ 5
Paraffin	_____ 1	_____ 2	_____ 3	_____ 4	_____ 5
Relaxation techniques	_____ 1	_____ 2	_____ 3	_____ 4	_____ 5
Sensory arousal techniques	_____ 1	_____ 2	_____ 3	_____ 4	_____ 5
Therapeutic exercise	_____ 1	_____ 2	_____ 3	_____ 4	_____ 5
Facilitation/Inhibition tech.	_____ 1	_____ 2	_____ 3	_____ 4	_____ 5
Rood approach	_____ 1	_____ 2	_____ 3	_____ 4	_____ 5
Brunstrom approach	_____ 1	_____ 2	_____ 3	_____ 4	_____ 5
Bobath approach	_____ 1	_____ 2	_____ 3	_____ 4	_____ 5
PNF approach	_____ 1	_____ 2	_____ 3	_____ 4	_____ 5
Ayres S.I. Approach	_____ 1	_____ 2	_____ 3	_____ 4	_____ 5
Oral motor evaluation	_____ 1	_____ 2	_____ 3	_____ 4	_____ 5
Oral motor facil /inhibition	_____ 1	_____ 2	_____ 3	_____ 4	_____ 5
Splinting	_____ 1	_____ 2	_____ 3	_____ 4	_____ 5
TENS	_____ 1	_____ 2	_____ 3	_____ 4	_____ 5

	Usually 75%	Frequently 74-50%	Occasionally 49-25%	Seldom 24-1%	Never 0%
Enabling Activities					
Skateboard	___ 1	___ 2	___ 3	___ 4	___ 5
Sanding board	___ 1	___ 2	___ 3	___ 4	___ 5
Stacking cones, blocks	___ 1	___ 2	___ 3	___ 4	___ 5
Table top perceptual exercise.	___ 1	___ 2	___ 3	___ 4	___ 5
Dressing practice boards	___ 1	___ 2	___ 3	___ 4	___ 5
Hardware practice boards	___ 1	___ 2	___ 3	___ 4	___ 5
Work simulators	___ 1	___ 2	___ 3	___ 4	___ 5
Energy conservation tech.	___ 1	___ 2	___ 3	___ 4	___ 5
Work simplification tech.	___ 1	___ 2	___ 3	___ 4	___ 5
Adaptive equipment	___ 1	___ 2	___ 3	___ 4	___ 5
acquisition	___ 1	___ 2	___ 3	___ 4	___ 5
manufacture	___ 1	___ 2	___ 3	___ 4	___ 5
training	___ 1	___ 2	___ 3	___ 4	___ 5
Other _____	___ 1	___ 2	___ 3	___ 4	___ 5
Performance Skills					
Mobility Training					
Wheelchair measurement	___ 1	___ 2	___ 3	___ 4	___ 5
Wheelchair selection	___ 1	___ 2	___ 3	___ 4	___ 5
Wheelchair management	___ 1	___ 2	___ 3	___ 4	___ 5
Transfer skills	___ 1	___ 2	___ 3	___ 4	___ 5
Community transportation	___ 1	___ 2	___ 3	___ 4	___ 5
Driver evaluation	___ 1	___ 2	___ 3	___ 4	___ 5
Driver training	___ 1	___ 2	___ 3	___ 4	___ 5
ADL					
Hygiene	___ 1	___ 2	___ 3	___ 4	___ 5
Grooming	___ 1	___ 2	___ 3	___ 4	___ 5
Feeding training	___ 1	___ 2	___ 3	___ 4	___ 5
Dressing	___ 1	___ 2	___ 3	___ 4	___ 5
Management of environment	___ 1	___ 2	___ 3	___ 4	___ 5
Communication skills					
Typing	___ 1	___ 2	___ 3	___ 4	___ 5
Computer operation	___ 1	___ 2	___ 3	___ 4	___ 5
Tape recorder	___ 1	___ 2	___ 3	___ 4	___ 5
Writing	___ 1	___ 2	___ 3	___ 4	___ 5
Environmental control systems	___ 1	___ 2	___ 3	___ 4	___ 5
Telephone usage	___ 1	___ 2	___ 3	___ 4	___ 5
Home/community living					
Home/personal safety	___ 1	___ 2	___ 3	___ 4	___ 5
Meal preparation & planning	___ 1	___ 2	___ 3	___ 4	___ 5
Shopping	___ 1	___ 2	___ 3	___ 4	___ 5
Money management	___ 1	___ 2	___ 3	___ 4	___ 5
Laundry/ironing/clothing care	___ 1	___ 2	___ 3	___ 4	___ 5
House cleaning	___ 1	___ 2	___ 3	___ 4	___ 5
Child care	___ 1	___ 2	___ 3	___ 4	___ 5
Time management					
Leisure planning	___ 1	___ 2	___ 3	___ 4	___ 5
Interpersonal/social interaction	___ 1	___ 2	___ 3	___ 4	___ 5

	Usually 75%	Frequently 74-50%	Occasionally 49-25%	Seldom 24-1%	Never 0%
Group Process					
Role playing/role rehearsal	1	2	3	4	5
Leading group activities	1	2	3	4	5
Discussion groups	1	2	3	4	5
Leisure/ Pre-vocational Activities					
Needlecrafts					
Hand sewing	1	2	3	4	5
Knitting	1	2	3	4	5
Crocheting	1	2	3	4	5
Embroidery	1	2	3	4	5
Needlepoint	1	2	3	4	5
Tatting	1	2	3	4	5
Hairpin crochet	1	2	3	4	5
Other _____	1	2	3	4	5
Yarn Crafts					
Braid weaving	1	2	3	4	5
Turkish knotting	1	2	3	4	5
Card weaving	1	2	3	4	5
Table loom weaving	1	2	3	4	5
Floor loom weaving	1	2	3	4	5
Macrame	1	2	3	4	5
Other _____	1	2	3	4	5
Ceramics/Pottery					
Ceramic decorating	1	2	3	4	5
Hand modeling	1	2	3	4	5
Potter's wheel	1	2	3	4	5
Sculpting	1	2	3	4	5
Other _____	1	2	3	4	5
Woodwork					
Hand tools(const. of small objects)	1	2	3	4	5
Wood kits	1	2	3	4	5
Machine woodworking					
Jig saw	1	2	3	4	5
Table saw	1	2	3	4	5
Band saw	1	2	3	4	5
Planer	1	2	3	4	5
Other _____	1	2	3	4	5
Printing					
Block printing	1	2	3	4	5
Silk screening	1	2	3	4	5
Letterpress printing (printing press)	1	2	3	4	5
Potato printing	1	2	3	4	5
Stamping (rubber stamps)	1	2	3	4	5
Other _____	1	2	3	4	5

	Usually 75%	Frequently 74-50%	Occasionally 49-25%	Seldom 24-1%	Never 0%
Fabric Arts					
Clothing const./machine sewing	1	2	3	4	5
Batik	1	2	3	4	5
Tie Dying	1	2	3	4	5
Fabric decoration, with paints	1	2	3	4	5
Fabric stenciling	1	2	3	4	5
Other _____	1	2	3	4	5
Metal Crafts					
Jewelry making: specify _____	1	2	3	4	5
Copper enameling	1	2	3	4	5
Copper molding (bowls/ashtrays)	1	2	3	4	5
Other _____	1	2	3	4	5
Minor Crafts					
Leatherwork					
Lacing	1	2	3	4	5
Stamping	1	2	3	4	5
Tooling	1	2	3	4	5
Kits	1	2	3	4	5
Decoupage	1	2	3	4	5
Cooper tooling	1	2	3	4	5
Paper crafts					
Origami	1	2	3	4	5
Construction paper objects	1	2	3	4	5
Collage	1	2	3	4	5
Paper mache	1	2	3	4	5
Tile mosaics	1	2	3	4	5
Plastic crafts	1	2	3	4	5
Stained glass	1	2	3	4	5
Basketry	1	2	3	4	5
Other _____	1	2	3	4	5
Art Activities					
Water color	1	2	3	4	5
Oil painting	1	2	3	4	5
Charcoal sketching	1	2	3	4	5
Pastel sketching	1	2	3	4	5
Pencil sketching	1	2	3	4	5
Tempera/acrylics	1	2	3	4	5
Finger painting	1	2	3	4	5
Other _____	1	2	3	4	5
Games					
Non-competitive physical games	1	2	3	4	5
Competitive physical games	1	2	3	4	5
Competitive table games	1	2	3	4	5

	Usually 75%	Frequently 74-50%	Occasionally 49-25%	Seldom 24-1%	Never 0%
Computers for:					
Patient record keeping	___ 1	___ 2	___ 3	___ 4	___ 5
Word processing	___ 1	___ 2	___ 3	___ 4	___ 5
Cognitive retraining	___ 1	___ 2	___ 3	___ 4	___ 5
Other _____	___ 1	___ 2	___ 3	___ 4	___ 5
Video Skills					
Recording (operate camera)	___ 1	___ 2	___ 3	___ 4	___ 5
Editing	___ 1	___ 2	___ 3	___ 4	___ 5
VCR operation	___ 1	___ 2	___ 3	___ 4	___ 5
Work Evaluation/Hardening					
Physical Capacity Eval	___ 1	___ 2	___ 3	___ 4	___ 5
G.U.L. H.E.M.P.	___ 1	___ 2	___ 3	___ 4	___ 5
Purdue Pegboard Test	___ 1	___ 2	___ 3	___ 4	___ 5
Crawford Small Parts Dext. Test	___ 1	___ 2	___ 3	___ 4	___ 5
Minnesota Manual Dext. Test	___ 1	___ 2	___ 3	___ 4	___ 5
Hester Evaluation System	___ 1	___ 2	___ 3	___ 4	___ 5
McCarron Dial Work Eval System	___ 1	___ 2	___ 3	___ 4	___ 5
Tower System	___ 1	___ 2	___ 3	___ 4	___ 5
Valpar Comp. Work Sample Series	___ 1	___ 2	___ 3	___ 4	___ 5
Singer Voc. Eval System	___ 1	___ 2	___ 3	___ 4	___ 5
Wide Range Employ. Sample Test	___ 1	___ 2	___ 3	___ 4	___ 5
B.T.E. Work Simulator	___ 1	___ 2	___ 3	___ 4	___ 5
Work Capacity Eval.	___ 1	___ 2	___ 3	___ 4	___ 5
Jewish Employ. Voc. System	___ 1	___ 2	___ 3	___ 4	___ 5
W.E.S.T.	___ 1	___ 2	___ 3	___ 4	___ 5
Work Samples	___ 1	___ 2	___ 3	___ 4	___ 5
Work Tolerance Eval Training	___ 1	___ 2	___ 3	___ 4	___ 5
Work Habits & Attitudes	___ 1	___ 2	___ 3	___ 4	___ 5
Other: _____	___ 1	___ 2	___ 3	___ 4	___ 5

APPENDIX B
COVER LETTER

School of Applied Arts and Sciences • Department of Occupational Therapy
One Washington Square • San Jose, California 95192-0059 • 408/924-3070

November 15, 1988

Dear Field Work Coordinator:

The Department of Occupational Therapy is in the process of reviewing skill courses in it's curriculum in an effort to continue to prepare our students for field work and professional practice. We are interested in determining which activities are in use and which skills are required in current clinical practice.

Enclosed you will find a questionnaire. We would appreciate your cooperation in completing a questionnaire for each area of practice in your setting (physical dysfunction, psychiatric, or developmental disabilities).

Please return the questionnaire by December 5, 1988.

Sincerely yours,

Roberta K. Eyler
Roberta Eyler, M.Ed., OTR
Chair, Curriculum Committee

RE:bh