Conditions in Occupational Therapy

Effect on Occupational Performance
To my wife, Marcia, my best friend.

— Ben Atchison

To Mom and Hervey, from whom I learned the meaning of hard work.

— Diane Dirette
Preface

The goals of this textbook were the same in previous editions: to provide a framework for students to learn about common conditions seen by occupational therapists and to facilitate the teaching and learning of conditions from an occupational therapy perspective. We thank Dr. Ruth Hansen for her significant contributions to the development of this framework and her significant contributions as first editor in the first and second editions of this textbook.

The original goals of this book have not changed in this fourth revised edition of Conditions in Occupational Therapy: Effect on Occupational Performance. Although not all conditions that an occupational therapist will encounter are included, we discuss those most common to our practice.

All chapters have the same basic structure, including sections on etiology, incidence and prevalence, signs and symptoms, course and prognosis, and medical/surgical management. The information is synthesized from an occupational performance perspective, using language included in the Occupational Therapy Practice Framework. It is important to begin the occupational therapy process with an understanding of client factors, including body structures and functions associated with a given condition, and to examine the potential effect on the occupational performance areas.

In this edition, the Occupational Therapy Practice Framework language, which is the most current “language of the profession,” is inserted. We are pleased to announce the addition of several new chapters in this edition. These include Developmental Trauma Disorder, Infectious Diseases, Low Vision Disorders, and Muscular Dystrophy, as well as major revisions across all chapters to ensure current information on all aspects of these selected conditions. Case studies have been updated and are included for each chapter.

There is a continuing discussion in our profession about whether occupational therapists “treat diagnoses.” We do not propose that there be an emphasis on the treatment of a diagnosis. We understand and support a patient-first philosophy. We do, however, argue that there are specific factors that impact on the ability to perform occupational roles and functions that are unique to a given condition. These factors must be understood and analyzed regarding their relative impact on the patient’s ability to participate and engage in daily activity.

Each chapter in this fourth edition provides the authors’ interpretations of the effects of the condition on occupational performance. This analysis is not absolute. Those who use this book may disagree about the importance of various disabilities and the secondary changes that might occur. That process, however, is the key to our goal for publishing this book. We expect it to be a starting point for discussion and analysis of the condition and its impact on occupational performance.

Ben Atchison
Diane Dirette
Contributors

Ben J. Atchison, PhD, OTR/L, FAOTA
Professor
Department of Occupational Therapy
Western Michigan University
Kalamazoo, Michigan

Jennifer L. Forgach, MS, OTR/L
Children’s Hospital of Michigan
Detroit, Michigan

Joyce Fraker, MS, OTR
Department of Psychiatry
Ann Arbor VA Medical Center
Ann Arbor, Michigan

Paula W. Jamison, PhD, OTR/L
Professor Emeritus
Department of Occupational Therapy
Western Michigan University
Kalamazoo, Michigan

Laura V. Miller, MS, OTR/L, CDI, CDRS
Private Practice
Livonia, Michigan

Brandon G. Morkut, MS, OTR/L
VanBuren Intermediate School District
Lawrence, Michigan
Clinical Faculty
Department of Occupational Therapy
Western Michigan University
Kalamazoo, Michigan

Karin J. Opacich, PhD, MHPE, OTR/L, FAOTA
School of Public Health
University of Illinois
Chicago, Illinois

David P. Orchanian, MPA, OTR
Master Clinical Faculty Specialist
Department of Occupational Therapy
Western Michigan University
Kalamazoo, Michigan

Sharon L. Pavlovich, M.A.M, COTA/L
Department of Occupational Therapy
Loma Linda University
Loma Linda, California
CONTRIBUTORS

Elizabeth L. Phillips, PhD, RN
Bronson School of Nursing
Western Michigan University
Kalamazoo, Michigan

Kathryn M. Shangraw, MA, CCC-SLP
Grand Rapids Public Schools
Grand Rapids, Michigan

Michelle A. Suarez, PhD c, OTR/L
Assistant Professor
Department of Occupational Therapy
Western Michigan University
Kalamazoo, Michigan

Christine K. Urish, PhD, OTR/L, BCMH, FAOTA
Professor
Department of Occupational Therapy
St. Ambrose University
Davenport, Iowa

Andrea L. Washington, BS, OTR/L
Children's Hospital of Michigan
Detroit, Michigan

Mary Steichen Yamamoto, MS, OTR/L
Private Practice
Ann Arbor, Michigan
Davenport, Iowa
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Thinking Like an OT

diane Dirette
Ben Atchison

KEY TERMS
Altruism
Client factors
Context
Dignity
Equality
Freedom
Justice
Performance in areas of occupation
Performance patterns
Performance skills
Person-first language
Prudence
Truth

It is more important to know what kind of person has the disease than what kind of disease the person has.
—Sir William Osler (Address at Johns Hopkins University, February 1905)

Lindsey is finishing her course work in occupational therapy and is now beginning her first level II fieldwork experience. Throughout her education, she has learned the importance of evidence-based practice to guide her treatment decisions. Her challenge now is to develop her clinical reasoning skills to merge the science she has learned with the art of practice. To achieve this, she must understand the person’s diagnosis, analyze the person’s unique set of problems based on the person’s individual characteristics and determine the impact on occupational performance. The first step of this process is the referrals she receives. Each referral gives her some basic information about the person including the person’s diagnosis. Her job is to decide what to do next.

How does a student learn to correlate general information about a diagnosis with the needs of a particular person and to identify the problems that require occupational therapy intervention? How does a staff therapist set priorities for problems and decide which require immediate attention? How much problem identification can be done before the therapist actually sees the patient? How does a supervisor know when a student or therapist is doing a “good job” of screening referrals and anticipating the dysfunction that the patient might be experiencing? These are precursors to the actual intervention process and are essential to effective and efficient clinical reasoning (Benamy, 1996).

The clinical reasoning procedure used by each health care professional is somewhat different. The information that is the main focus of intervention for a speech therapist will differ from that of a psychologist or a nurse. What makes occupational therapy unique among health care professions is that practitioners gather and use information to help people become self-sufficient in their daily activities. Such
data gathering and analysis provide the therapist with the foundation for a treatment plan through a prioritized list of anticipated problems or dysfunctions for an individual.

To comprehend the unique aspects of occupational therapy requires an understanding of the core values, philosophical assumptions, and domain of concern of the profession, as well as the language that is used to communicate information clearly and precisely.

**CORE VALUES OF OCCUPATIONAL THERAPY**

The core values of occupational therapy are set forth in the document “Core Values and Attitudes of Occupational Therapy Practice” (Kanny, 1993). Seven have been identified: altruism, dignity, equality, freedom, justice, truth, and prudence.

1. **Altruism** is the unselfish concern for the welfare of others. This concept is reflected in actions and attitudes of commitment, caring, dedication, responsiveness, and understanding.
2. **Dignity** emphasizes the importance of valuing the inherent worth and uniqueness of each person. This value is demonstrated by an attitude of empathy and respect for self and others.
3. **Equality** requires that all individuals be perceived as having the same fundamental human rights and opportunities. This value is demonstrated by an attitude of fairness and impartiality.
4. **Freedom** allows the individual to exercise choice and to demonstrate independence, initiative, and self-direction.
5. **Justice** places value on the upholding of such moral and legal principles as fairness, equity, truthfulness, and objectivity.
6. **Truth** requires that we be faithful to facts and reality. Truthfulness or veracity is demonstrated by being accountable, honest, forthright, accurate, and authentic in our attitudes and actions.
7. **Prudence** is the ability to govern and discipline oneself through the use of reason. To be prudent is to value judiciousness, discretion, vigilance, moderation, care, and circumspection in the management of one’s affairs, to temper extremes, make judgments, and respond on the basis of intelligent reflection and rational thought (Kanny, 1993).

These values are the foundation of the belief system that occupational therapists use as a moral guide when making clinical decisions.

**PHILOSOPHICAL ASSUMPTIONS**

The philosophical assumptions of the profession guide occupational therapists in providing client-centered therapy that meets the needs of the client and society. These assumptions express our basic beliefs about the client and the context in which the client functions (Mosey, 1996). These assumptions are as follows:

Each individual has a right to a meaningful existence: the right to live in surroundings that are safe, supportive, comfortable, and over which he or she has some control; to make decisions for himself or herself; to be productive; to experience pleasure and joy; to love and be loved.

Each individual is influenced by the biologic and social nature of the species.

Each individual can only be understood within the context of his or her family, friends, community, and membership in various cultural groups.

Each individual has the need to participate in a variety of social roles and to have periodic relief from participation.

Each individual has the right to seek his or her potential through personal choice, within the context of accepted social constraints.

Each individual is able to reach his or her potential through purposeful interaction with the human and nonhuman environment.

Occupational therapy is concerned with promoting functional interdependence through interactions directed toward facilitating participation in major social roles (areas of occupational performance); and development of biologic, cognitive, psychological, and social components (client factors) fundamental to such roles.

The extent to which intervention is focused on the context, the areas of occupational performance, or on the client factors depends on the needs of the particular individual at any given time.

**LANGUAGE**

Although many language systems and mechanisms are available, we will discuss language from two perspectives. First is a philosophical discussion of using person-first language. Second is the use of the Occupational therapy practice framework: domain and process, 2nd edition (American Occupational Therapy Association [AOTA], 2008), which presents the professional language and the occupational therapy domain of concern.
**Person-First Language**

In many cases the literature and the media, both popular and professional, describe a person with a given condition as the condition—the arthritic, the C.P. kid, the schizophrenic, the alcoholic, the burn victim, the mentally retarded. All of these terms label people as members of a large group rather than as a unique individual. The use of person-first language requires that the person be identified first and the disease used as a secondary descriptor. For example, a woman, who is a physicist, is active in her church and has arthritis; the fourth-grade boy, who is a good speller, loves baseball and has cerebral palsy. The condition does not and should not be the primary identity of any person.

Consider the following: a father is introducing his son to his coworkers. Which of the following is the best introduction:

"Hey, everyone, this is my retarded son, John."

"Hey, everyone, this is my son, John, who is retarded and loves soccer and video games."

"Hey, everyone, this is my son, John. He loves soccer and video games."

Of course, the third statement is the best choice. Yet it is common when describing a person who has a disability to emphasize the disability first. The consequence is a labeling process. Although such shorthand language is commonplace in clinics and medical records, it negates the individuality of the person. Each of us is a person, with a variety of traits that can be used to describe aspects of our personality, behavior, and function. To use a disease or condition as the adjective preceding the identifying noun negates the multiple dimensions that make the person a unique individual (Hansen, 1998).

**THE OCCUPATIONAL THERAPY PRACTICE FRAMEWORK**

The professional language for the profession of occupational therapy was revised in 2008 and presented in a document titled the “Occupational Therapy Practice Framework: Domain and Process,” second edition (AOTA, 2008). The Practice Framework outlines the language and constructs that describe the occupational therapy profession's domain of concern. The domain defines the area of human activity to which the occupational therapy process is applied. The process facilitates engagement in occupation to support participation in life. The focus of the process is on the use of and the enhancement of engagement in occupation. The specific aspects of the domain are outlined in Table 1.1.

The Framework is organized into six aspects—performance in areas of occupation, performance skills, performance patterns, context, activity demands, and client factors. **Performance in areas of occupation** are broad categories of human activity that are typically part of daily life. The areas include activities of daily living, instrumental activities of daily living, education, work, and play, leisure, and social participation. **Performance skills** are features of what a person does during an activity. These skills are separated into the categories of motor skills, process skills, and communication/interaction skills. **Performance patterns** are the habits, routines, and roles that a person adopts. **Context** refers to the conditions that surround the person. Those conditions include cultural, physical, social, personal, spiritual, temporal and virtual contexts. **Activity demands** are the aspects of the task that influence the performance by the person. These demands include the objects used and their properties, space demands, social demands, sequencing and timing, required actions, required body functions and required body structures. **Client factors** are the body functions and the body structures that reside within the person (Fig. 1.1) See Table 1.1 for an overview of the practice framework domains.

Each of these aspects has a relationship with and influence on the others. The outcome is, of course, the ability to function and engage in occupations. Although at a given time you may focus on areas of occupation or client factors, the ultimate concern is whether the individual is able to perform necessary and desired tasks in daily life. For example, a therapist may evaluate a person's attention span, but not in isolation. Attention span is evaluated within the realm of the performance patterns and context of the person—attention span required to work on an assembly line, to drive a car, to learn a card game, or to conduct a business meeting.

Once you know the diagnosis and age of the person, you can use this Practice Framework to examine systematically the deficits that occur in the client factors (described in Figure 1.1) as well as how these particular deficits can and do alter the person's ability to complete tasks in relevant areas of occupational performance. In other instances, you may focus primarily on the area of occupational performance or the contextual factors for the individual, without paying much attention to the underlying client factors that influence the performance areas.

**EVIDENCE-BASED PRACTICE**

There has been a call to action in the health professions to practice health care based on evidence of the effectiveness of each treatment approach (Gutman, 2010). High levels of evidence are based on studies that compare groups of
people, usually with similar diagnoses. Evidence, especially high levels of evidence, on which to base one’s practice, however, might be limited (Dirette, Rozich & Vau, 2009). First, it is limited by an insufficient number of resources to support specific treatment approaches with specific diagnoses. Second, it might be limited by the fact that groups of people with “average” results do not always represent the unique situation of the person with whom the therapist is working.

Therefore, while we support the idea of evidence-based practice in general, there is clearly a need for therapists to develop clinical reasoning skills that will not only help them decide which evidence to use with particular diagnoses but also help them decide what to do with the unique individual with whom they are working. Understanding the diagnosis with which the individual presents is often the first step in the clinical reasoning process. This textbook provides information about common diagnoses seen by occupational therapists and provides the first steps in the clinical reasoning process by providing ideas about the potential impact on occupational performance.
Whereas the primary purpose of this book is to describe the potential impact of a condition on occupational performance, the descriptions should not be considered prescriptive or exhaustive. It is necessary to understand common facts of these conditions, including etiology, basic pathogenesis, commonly observed signs and symptoms, and precautions. However, it is equally important to recognize that the effects of a condition on occupational well-being will also be dependent on contextual factors such as age, developmental stage, health status, and the physical, social, and cultural environment (Dunn, Brown, & McGuigan, 1994). Rather than viewing an individual as a diagnostic entity or as the sum of biologic cells, the condition must be personalized.

The general organization of each chapter is similar to previous additions. First, there are descriptions and definitions followed by information about the etiology, incidence and prevalence, signs and symptoms, course and prognosis, and medical/surgical management. This book is unique because the authors have used these details to generate a description of the various aspects of occupational performance that might be affected. At the end of each chapter is a discussion of at least one case study. Cases provide a beginning point to discuss specific details about how the condition might impact the daily functioning of a person.

Occupational therapists have a unique and valuable view of an individual as an occupational being. All

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**TABLE 1.1 Occupational Therapy Practice Domains**

<table>
<thead>
<tr>
<th>Areas of Occupation</th>
<th>Client Factors</th>
<th>Performance Skills</th>
<th>Performance Patterns</th>
<th>Context and Environment</th>
<th>Activity Demands</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activities of daily living (ADL)*</td>
<td>Values, beliefs, and spirituality</td>
<td>Sensory perceptual skills</td>
<td>Habits</td>
<td>Cultural</td>
<td>Objects used and their properties</td>
</tr>
<tr>
<td>Instrumental activities of daily living (IADL)</td>
<td>Body functions</td>
<td>Motor and praxis skills</td>
<td>Routines</td>
<td>Personal</td>
<td>Space demands</td>
</tr>
<tr>
<td>Rest and sleep</td>
<td>Body structure</td>
<td>Emotional regulation skills</td>
<td>Roles</td>
<td>Physical</td>
<td>Social demands</td>
</tr>
<tr>
<td>Education</td>
<td>Cognitive skills</td>
<td>Rituals</td>
<td>Social</td>
<td>Social demands</td>
<td>Sequencing and timing</td>
</tr>
<tr>
<td>Work</td>
<td>Communication and social skills</td>
<td></td>
<td>Temporal</td>
<td>Required actions</td>
<td></td>
</tr>
<tr>
<td>Play</td>
<td></td>
<td></td>
<td>Virtual</td>
<td>Required body functions</td>
<td></td>
</tr>
<tr>
<td>Leisure</td>
<td></td>
<td></td>
<td></td>
<td>Required body structures</td>
<td></td>
</tr>
<tr>
<td>Social participation</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

*Also referred to as basic activities of daily living (BADL) or personal activities of daily living (PADL).

of us attach meaning to our lives and the lives of others through the activities and occupations that are part of our daily existence. Occupation, then, means more than just work. It is a much broader concept that refers to human involvement in activities that will result in productive and purposeful outcomes. It also includes participation in leisure, rest, and self-care activities that some may not consider productive and purposeful. For example, the occupations of a 3-month-old infant include those that could be categorized under the general headings of play or activities of daily living. Activities such as play exploration, socialization, and functional communication are critical at this age.

The complexity of occupation changes dramatically as the infant progresses toward preschool and school age. It is interesting to observe the rapid addition of new occupational roles and expectations as the child enters school. Many aspects of occupational development are emerging. For example, a 7-year-old child participating in classroom activities is involved in a type of work. Being on time, turning in assignments that are completed properly, good grooming, and getting along with others are all behaviors that will be important as the child approaches adulthood.

Adults are expected to assume, independently pursue, and maintain relevant occupations. In general, adults spend the greater portion of their waking hours engaged in some type of work or instrumental activities of daily living. These occupations may be a job or vocation that is done for pay, organized volunteer activities, or home management. The percentage of time spent in each area is largely determined by the role the individual assumes. In addition, adults spend a portion of their time exploring and performing leisure and social activities. Activities of daily living, sexual expression, grooming, and eating are also important for adults.

The basic tenets regarding occupational performance are that these tasks are critical and must be performed by the person or by others to survive. By engaging in various occupations, the person develops, learns adaptive mechanisms, and meets individual needs. It is important to understand the influence of culture on adaptation. Cultural influences, such as institutions, rules, values,