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Cover photograph:
Toi toi
by ‘Adiemus: Bronnie Thompson’, (c) 2008
Toi toi (also spelt Toetoe and pronounced toy toy) is a tall native New Zealand grass, from the Cortaderia species. With its plume-like flower heads, from late spring and throughout summer, the Toi toi is found throughout New Zealand and is as iconic as the Cabbage tree.
New Zealand Journal of Occupational Therapy
Is an official publication of the New Zealand Association of Occupational Therapists Inc. You may visit our web site at www.nzaot.com

Aims and scope
The New Zealand Journal of Occupational Therapy is dedicated to the publication of high quality national and international articles that are grounded in practice. We invite practitioners, researchers, teachers, students and users of services to submit manuscripts that provide a forum to discuss or debate issues relevant to occupational therapy. These will be reviewed promptly and, if accepted, will be published in a timely manner.

Editorial correspondence
Papers and other material for publication should be sent to the
Editor: Grace O’Sullivan
New Zealand Journal of Occupational Therapy
PO Box 10493
The Terrace
Wellington 6143
New Zealand
Phone: +64 9 410 9541
Email: sullies@xtra.co.nz

For details related to the submission of manuscripts please refer to the Guidelines for Authors, available in this publication or from the Association web site.

Associate editors
Dr Mary Butler & Kathy Pauga

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The Journal is published twice a year and the prices for 2009 are as follows:
- For NZAOT members - NZ$40 in New Zealand, NZ$47 in Australia and the Pacific, and NZ$52 for the rest of the world.
- For non NZAOT members and institutions - NZ$70 in New Zealand, NZ$80 in Australia and the Pacific, and NZ$88 for the rest of the world.

Subscription enquiries should be directed to:
Executive Director
New Zealand Association of Occupational Therapy
PO Box 10493
The Terrace
Wellington 6143
New Zealand
Phone: +64 473 6510
Fax: +64 473 6513
Email: nzaot@nzaot.com

Abstracting and indexing
The Journal is now indexed in the CINAHL, the OT SEARCH database and the OTDBASE.

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The Association or the Editor cannot be held responsible for errors or any consequences arising from the use of information published in this Journal. Opinions expressed in articles and letters do not necessarily represent those of the Association or of the Editor. Publication of advertisements does not constitute any endorsement by the Association or the Editor.
The articles in this issue of the Journal cover some interesting topics. Presented in reverse chronology (often we go from youngest to oldest, this time we are going from oldest to youngest), Dorrestein and Hocking consider the ways in which occupational therapy can be used to maximize opportunities for older people who live in residential care to participate in daily activities, and thus enhance their quality of life. The focus is on the provision of choices that will make life more meaningful. Brown, Morrison, and Stagnitti explore the similarities and differences between the occupational therapy assessment tools used to address sensory problems which impact on school aged children's occupational performance. The knowledge derived from assessing a child's sensory needs improves understanding of the root causes of what may be classed as behavioural problems. A case study from Scaletti and Hocking, describes the use of story telling as a means of understanding how traumatic events may affect children. Stories are the therapeutic medium used to help children to relate experiences of grief and loss.

The final article in this edition has been taken from the archives, circa 1960s. The vintage paper is one of the very early papers exploring approaches to therapy for children. The article describes the methods used to 'treat' children deemed to be delinquent. Intended to complement the item from Scaletti and Hocking, sixty years on, this paper makes interesting reading and raises questions for today's practitioner: How well do we respond to the needs of children these days?

Of note, in both articles is the use of a sand tray in therapy.

Further, I am pleased to congratulate Shoba Nayar on a worthy achievement. Shoba, who recently qualified as a Doctor of Philosophy, shares the abstract from her thesis submitted to the Department of Occupational Science and Therapy, AUT University.

I often wonder if anybody out there actually reads this page. Do let me know, I welcome your comments and feedback on the content of the Journal. I hope you enjoy this issue of the New Zealand Journal of Occupational Therapy. Feel free to pass it on to colleagues.

Acknowledgement
Once again I want to acknowledge occupational therapists who have given their time and used their knowledge to review manuscripts submitted for publication during 2009/10. The Journal and its readers are privileged to have your support.

To Alexa Andrews, Ann Christie, Beth Gordon, Carolyn Simmons Carlsson, Clare Hocking, Ellen Nicholson, Helen Byrne, Janet Phare, Kathy Pauga, Mary Butler, Rowena Scaletti, Sandy Rutherford, and Tim Dunn – many, many thanks.

Grace O'Sullivan
(Editor)
Letter to the editor

Occupational therapy between cultural competency and colonization.


I am writing in response to the article titled “Embracing Diversity: Explaining the cultural dimensions of our occupational therapeutic selves” by Dr Michael Iwama (2007). There have been constant calls over the last 10 years for reflection on, and re-examination of the deep tenets of occupational therapy. The work of Dr Iwama represents one of those daring and challenging calls.

Through the latter article, Iwama (2007) was emphasizing that the re-examination and reconstruction of the deep philosophy of occupational therapy to enable a culturally competent practice needs to start from the ontological and epistemological view adopted in that regards. The article seems to favour the view that truth is a relative, multiple and changing concept and it cannot be universal (Iwama 2003; Iwama 2007). It may even seem unrealistic to have a fixed cultural identity for occupational therapy profession within the various cultural truths and realities (Iwama 2003; Iwama 2007). Yet cultural competency cannot be achieved by stripping occupational therapy of power and turn it into a completely client-led profession. Occupational therapy philosophy needs to be defined according to a set of fixed principles and beliefs; otherwise it may run the risk of losing identity and ultimately face extinction.

Iwama (2003) argued that occupational therapy needs to be adapted to suit the cultural needs and idiosyncrasies of each cultural context. This is possible within the fixed tenets of occupational therapy that makes occupational therapy what it is. Thus the way to achieve cultural competence may lie in creating the balance between working according to the concurrent fixed and biased occupational therapy philosophy and the various cultural backgrounds (Iwama 2003; Iwama 2007). Therapists may struggle to find the balance between working according to the concurrent fixed and biased occupational therapy philosophy and the various cultural backgrounds (Iwama 2003; Iwama 2007). It may even seem unrealistic to have a fixed cultural identity for occupational therapy profession within the various cultural truths and realities (Iwama 2003; Iwama 2007). Yet cultural competency cannot be achieved by stripping occupational therapy of power and turn it into a completely client-led profession. Occupational therapy philosophy needs to be defined according to a set of fixed principles and beliefs; otherwise it may run the risk of losing identity and ultimately face extinction.

It is uncommon to halt and take some time to reflect on our professional philosophy and how it was constructed and how it influences our practice. I would like to congratulate Dr Michael Iwama for his work which addresses an earnest need in occupational therapy to question its deep underpinnings and philosophy.

References:
Devlieger, P. & Balcazar, F. (2010). ‘Bringing them back on the right track’: Perceptions of medical staff on the rehabilitation of individuals with violently acquired spinal cord injuries. Disability & Rehabilitation, 32(6), 444-51 C

Wesam Barakat Darawsheh
MSc Occupational Therapy;
BSc Occupational Therapy
PhD candidate (Occupational Therapy)
School of Health and Human Sciences
University of Essex
Wivenhoe Park
Colchester CO4 3SQ
Essex
UK
Email: wbmdar@essex.ac.uk
Maximising participation for older people:  
Scoping the occupational therapy role 
in residential care settings

Marlies Dorrestein and Clare Hocking

Abstract
Based on the first author’s experience, options for occupational therapy practice within the New Zealand aged residential care sector are explored in light of current legislation, stretched health care funding, organisational challenges, and the increased dependence of residents. Literature from a variety of disciplines and perspectives is used to inform and support the investigation. A framework with six discrete focuses is presented to assist occupational therapists to conceptualise and prioritise their actions. Information about the needs, skills, and knowledge of residents, caregivers, and managers is outlined, along with approaches to the delivery of occupational therapy services that maximise opportunities for residents’ occupational engagement and participation in life.

Key words
Occupational outcomes, occupational therapy role, residential care, older people, participation.

Reference

This article proposes a response to the question: what occupational therapy input will best serve to increase occupational opportunities and limit barriers to participation for older people in residential care? Furthermore, the article addresses some of the complexities facing an occupational therapist contracted or employed to provide services within aged care facilities in New Zealand.

Various factors impacting on services informed the conceptualisation of a proposed practice framework for the provision of occupational therapy in residential care facilities. This includes rest homes, private hospitals and secure dementia care units. The need for an evidence-based, systemically targeted approach to service provision is identified in light of the limited resources available to attend to individual residents’ occupational needs. In order to maximise health and well being, the framework addresses responsibilities for residents’ occupational needs at multiple levels within a residential care organisation.

The rationale for developing the framework was to guide decision making about the occupational therapy role in a residential practice context. By distinguishing three different approaches: direct service delivery (working with residents); educational (working with staff); and policy development (working with management), the framework identifies the building blocks of a viable occupational therapy service. In order to highlight the significance of this, it is useful to explore some of the issues contributing to the current situation in aged care and discuss factors that provide potential solutions.

The imperative to action
In 2006, O’Sullivan and Hocking comprehensively and convincingly addressed the challenging issues facing positive ageing in residential care in New Zealand. They described...
serious concerns regarding the prevailing climate of occupational deprivation in care situations and identified several barriers to achieving positive health and well being for people in residential care. An expectation of passivity and frailty by staff, economic factors (funding and wages), and limited staff training were examples given. O’Sullivan and Hocking based their argument on literature from a variety of disciplines, which describe the benefits of physical activity, personal control and self efficacy (p. 18), being in a vibrant and cohesive community, and maintaining a sense of self through occupation (p. 19). Similarly in Australia, Snowden and Fleming (2008) described “grief over loss of opportunities and abilities to take part in valued activities, …not being involved in helping others, and attending but not taking part in activities” as “factors most highly associated with development of depression” (p. 298). Spurred on by these perspectives, we embarked on a reconsideration of the occupational therapist’s role in residential care services for older people, and how occupation could be brought into focus. The first step was to search the professional literature and government policies for insights and support.

Defining health and health care
In order to do justice to quality of life and healthcare issues for older people in residential care, the importance of providing effective occupational therapy services needs to be argued at several levels. In relation to the multiple and complex health-related challenges older people face, it should be acknowledged that the ultimate purpose of healthcare is more than the absence of disease. This has been endorsed by the World Health Organization’s (2001) International Classification of Functioning, Disability and Health (ICF). Hocking (2003) described the ICF’s proposal in occupational terms as: “helping people to participate in the everyday occupations that give life meaning” (p. 189). Achieving that has been described as “removing obstacles to the achievement of biological or chosen human potentials” (Seedhouse, 1998, p. 6) and, consistent with occupational therapists’ understandings of the therapeutic power of occupation, as “human flourishing” (Seedhouse, p. 44). In addition, continued engagement in occupation has long been identified as an approach that has many benefits for the health and well being of people throughout the life span (Atchley, 1989; Csikszentmihalyi, 1993; O’Sullivan, 2004; Wenborn, 2005; Wilcock, 1998; Yuen, Huang, Burik, & Smith, 2008).

Legislative, theoretical and managerial contexts
The following sections provide further background to the barriers which inhibit the provision of an effective occupational therapy service. The discussion will then move towards potential solutions and ways of synthesizing and articulating a useful response.

Legislative context
The legislative context contributes both to a solution and to the challenge of providing occupational therapy in residential care for older people. A holistic approach to positive ageing and healthcare provision for older people in New Zealand is supported by the 10 principles of the Positive Ageing Strategy (Ministry of Social Policy, 2001), the Health and Disability Services (Core) Standards (Standards New Zealand, 2008), in particular Standard 3.7, (p. 15) which is embedded in the Continuum of Service Delivery, the content of the Aged Related Residential Care Services Agreement (Ministry of Health, 2002), and the tenor of the Guideline for Specialist Health Services for Older People (Ministry of Health, 2004). Moreover, the Guideline (Ministry of Health, 2004) and the current concept of “aging in place” as described in the New Zealand Positive Ageing Strategy (Ministry of Social Policy, 2001), enable older people to remain in the community in their own homes for as long as possible. This is widely thought to contribute to quality of life in old age. While the implementation of these policies supports older people to remain in the community longer, when they do enter residential care, they have a higher level of impairment and more complex health needs. Therefore, the residents require more skilled support to enable them to engage in chosen and valued occupations.

Health promotion
In an article specifically focusing on the application of health promotion principles in long term care, Minkler (1984) asserted that “a broader approach to health promotion is seen as having important potential for improving the health and quality of life of elders in long-term care” (p. 81). Minkler cited Green’s (1980) definition of a broader approach to health promotion as: “any combination of health education and related organizational, political and economic intervention designed to facilitate behavioural and environmental changes conducive to health” (p. 80).

Similarly, Thibeault and Hebert (1997) stated that the principles of health promotion closely align with occupational therapy principles and philosophy. These principles are: community participation, empowerment, greater autonomy for the community, the importance of active and meaningful lifestyles, and respect for cultural diversity (Thibeault & Hebert, pp. 274-275). Both descriptions provide a comfortable fit with what O’Sullivan and Hocking (2006) described as contributing factors to positive ageing.

Occupational therapy: A theoretical context
Although members of the occupational therapy profession have a long history of working in aged care facilities, that work has been described as having an “uncertain ideology” (Hasselkus, Dickie & Gregory, 1997, p. 132). Accordingly, occupational therapists have been urged to consider the “fundamental task of reconciling the realities of practice with traditional rehabilitation ideologies, by redefining themselves and their roles in practice” (Hasselkus et al., 1997). That might mean supporting residents to assert their autonomy in utilising occupational opportunities for independence and in their “potential for continued growth, no matter how brief; their potential for achievement, no matter how small; and their creation of new options, no matter how mundane” (Crabtree & Caron-Parker, 1991, p. 611).

Three theoretical developments in the international literature
seem particularly pertinent to delivering occupational outcomes. First, the return to a paradigm with “occupation as the professional core” (Kielhofner, 2004, p. 64) and the process of enabling occupation proposed within the Canadian Model of Occupational Performance and Engagement (CMOP-E) (Townsend & Polatajko, 2007). In this paradigm the central focus is allowing “persons to more fully participate in necessary and desired occupations” (Kielhofner, p. 68), by removing restrictions and barriers thus supporting engagement in occupations. This theory supports direct occupational therapy intervention. Second, the World Health Organization’s (2001) recognition of the importance of activity and participation to health. Third, is the profession’s acknowledgment of the meaning of everyday occupation (Hasselkus, 2002). These models endorse the role of occupational therapists who work in residential care with a view to enabling residents “as best as possible to live the lives that lie within them” (Hasselkus, p. 19). In other words, to enable residents to “do real things and feel like real people” (Hasselkus et al., 1997, p. 136).

Additionally, both the Model of Human Occupation (MOHO) and CMOP-E may be applied to individuals, groups of individuals or an organisation. Reference to these models facilitates the implementation and development of occupational therapy services. Kielhofner (2008) expressed this in terms of programme development, “referring to creating and evaluating an approach to service delivery for a defined client group” (p. 442). In CMOP-E, the process is described in terms of “organising occupational therapy services that enable organisational change in collective issues such as occupational deprivation” (Townsend & Polatajko, 2007, p. 104). This may consist of evaluating how positive occupational outcomes can be achieved for individuals as well as groups of residents. To illustrate that point with a small but real example, one resident’s request for peanut butter instead of jam to put on her toast might be addressed by asking her family to bring in a jar, or by negotiating that peanut butter be added to the breakfast menu. In addition, creating enhanced occupational opportunities might become the shared responsibility of the occupational therapist, activities staff, and care giving staff.

**Managed care**

The structure of managed care may shed further light on the challenges facing an occupational therapist working in residential care while offering a partial solution. Managed care is a systems-focused approach “integrating the financing and delivery of health services” (American Occupational Therapy Association (AOTA), 1996, p. 1). It essentially focuses on the systems and financial control of healthcare (AOTA, 1996, p. 9). This approach has become prevalent in New Zealand, with corporate organisations owning a large number of supported living and residential care facilities. These organisations are faced with the challenge of providing quality healthcare whilst satisfying the financial expectations of shareholders. Wong (1998) described extensive ethical debate in the United States over whether this potential conflict in interests can be resolved. He pointed out the responsibilities of all the stakeholders in this situation. Occupational therapists employed by these organisations may feel an obligation to the organisation and its shareholders to provide highly productive, evidence-based, outcome-focused services with minimum resource requirements. The inherent tension is that the high support needs of the residents in rest homes, private hospitals and dementia units, demands increased time for care services (see “client-centred care” in the occupational therapy framework). Generally speaking, this is not available within the current employment situation in New Zealand.

**The employment context: Contractual obligations and opportunities**

Over the last 20 years there has been a significant decrease in occupational therapy roles that offer hands-on, direct care of residents both individually and in groups. The shift towards an advisory or consultative role is familiar for occupational therapists working in the private sector. Clearly, when faced with a contract for occupational therapy services for a limited number of hours per week, a service focused on working with individual residents will not serve the health and occupational needs of the total resident population in the facility, nor the financial constraints of the organisation.

North American literature provides strategies that will assist occupational therapists to provide services that best meet the occupational needs of residents. For instance, Rogers (1981) stated that “many of the positions in geriatric occupational therapy require indirect rather than direct service, involving consultation, supervision and programme planning” (p. 665). Similarly, Jaffe (1992) indicated that requests for service may focus on a combination of:

- A patient or case-focused traditional approach;
- An informational approach through seminars, in-service training or workshops;
- A process management-focused approach based on the processes of the organisation;
- A programme development approach focused on the activities service and/or the development of the occupational therapy service.

The consultation model highlighted by Jaffe (1992) offers an answer to the central concern of this paper: What can occupational therapists do to increase occupational opportunities and limit barriers to participation in residential care? What is more, Jaffe clearly indicated that to be effective occupational therapists must draw on multiple theoretical perspectives and work across all levels of the organisation to promote occupation.

**Developing occupational therapy services in residential care**

The well-documented challenges, barriers and limitations, and selected theoretical and contextual realities of addressing the occupational needs of older people living in residential care have been presented. The remainder of the article will consider occupational therapy input that could best redress these issues. It is important to realise that the process of addressing residents’
needs does not necessarily follow a linear or predictable time line (Rowles, 2000). Rather, in a complex situation where many issues need to be addressed, it is necessary to make a decision on where to start. The decision is shaped by pragmatic considerations, for instance certain strategies may need to be in place before change can occur. For example, reviewing the policies and documentation systems of the occupational therapy and activities service to ensure they reflect a client centred and occupational focus is a prerequisite to increasing activities staff knowledge. Similarly, increasing the activities staff members’ skills should be prioritised over individual interventions by the occupational therapist, because that has the potential to enhance residents’ occupational experience through the activity programme. Addressing this issue early in the service development process should be within the scope of an occupational therapist’s role.

Another factor influencing the prioritisation process is the occupational therapist’s skills and knowledge in relation to individual resident’s occupational needs. This could be considered a priority although there will be different needs within any organisation with multiple residential care facilities. Variation

Table 1. Occupation focused approach to occupational therapy services in residential care – based on a mixed advisory / practitioner role

<table>
<thead>
<tr>
<th>Clients or focus defined</th>
<th>Information required</th>
<th>Implementation of services</th>
<th>Occupation / participation outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Individual residents</strong></td>
<td>Identify residents who may benefit from or require specialised occupational therapy intervention Identify possibilities for a priority system Assessment of individual needs using specialist occupational therapy assessments, e.g. for seating, pressure care, environmental modifications, roles/habits/routines, occupational history &amp; potential Identify which individual needs may reflect other residents’ needs in order to make recommendations that will support group participation</td>
<td>Implement the occupational therapy process focusing on occupational / participation outcomes, following a recognised occupational therapy or other framework (e.g. CMOP, PEO, ICF) Referral to other specialist services and / or the activities programme Train care staff or activities staff in specific interventions or equipment use</td>
<td>Individual resident’s occupational performance and participation in life situations is maximised, by ensuring the best possible Person – Environment – Occupation (PEO) fit for the individual</td>
</tr>
<tr>
<td><strong>Senior &amp; registered staff of facility</strong></td>
<td>Knowledge of staff in relation to appropriate referrals to occupational therapy Effectiveness of procedures to follow up recommendations made for individual residents Adaptability of current communication systems for multi-disciplinary team approach (informal and formal e.g. MDT meetings) Staff expectations of the occupational therapist</td>
<td>Educate and facilitate teamwork with senior and registered staff about occupational therapy assessments, interventions and outcomes for residents Educate staff in referral of appropriately identified residents, perhaps using a structured referral form Establish most effective communication systems following assessment and for implementing recommendations for residents</td>
<td>Individual resident’s occupational performance and participation is increased, through appropriate referrals and follow up</td>
</tr>
<tr>
<td><strong>Residents with distinct characteristics and needs</strong></td>
<td>The extent to which there is a data gathering system that identifies which group or groups each resident falls within, in relation to: Service areas e.g. rest home, hospital, dementia care unit Functional levels e.g. minimal, moderate or full assistance requirements Interests, occupational history &amp; potential Evaluation of the extent to which occupational needs are met for each group (needs assessment)</td>
<td>Ensure relevant data are gathered to inform identification of group needs e.g. included in an initial assessment form Educate activities staff about activities programming for each identified resident group Set up a system for the occupational therapist to stay up to date with residents’ needs</td>
<td>Various groups of residents with similar needs / abilities / interests have access to appropriate needs-based organised activities on a regular and frequent basis</td>
</tr>
</tbody>
</table>
between facilities may help determine which aspects of service delivery will be addressed first. In other words, when faced with a complex service provision situation, an enabling occupation process may be applied to the whole service by assessing all the identified clients’ occupational performance issues. This can be achieved by selecting theoretical approaches, identifying components and environmental conditions, identifying strengths and weaknesses, and negotiating targeted outcomes before developing an action plan (Townsend et al., 1997).

Although there is no formula or established process for deciding where to start with the development of such services, some direction is provided in the literature, New Zealand policies about service delivery to older people, and the theories outlined above. Drawing on those sources, an overview of potential occupational therapy input is presented in Table 1. It serves as a ‘map of the terrain’ to assist with the prioritisation of services with the facility management and staff. Six different service areas are identified and briefly outlined below. More detailed guidance about the information required, the focus of assessment, implementation approaches, and participation outcomes are provided in Table 1.

### Individual residents

<table>
<thead>
<tr>
<th>Clients or focus defined</th>
<th>Information required</th>
<th>Implementation of services</th>
<th>Occupation / participation outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activities staff</td>
<td>Assess staff skills related to:</td>
<td>Provide support, mentoring and education to develop staff skills, as identified during the evaluation process. Implement new systems / processes as needed</td>
<td>Increased occupational engagement of residents</td>
</tr>
<tr>
<td></td>
<td>Interviewing / observation skills - activities assessment</td>
<td>Education for staff regarding new procedures / processes, via team meetings, formal and planned-in-service education days and facility based coaching of staff</td>
<td>Staff have knowledge and skills to implement a needs-based occupational programme of group and individual activities, utilising spaces within and around facilities (including the community) and other resources to optimize outcome potential</td>
</tr>
<tr>
<td></td>
<td>Writing individual activities plans as part of an integrated care plan</td>
<td>Facilitate teamwork within the service and across the facility</td>
<td></td>
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<tr>
<td></td>
<td>Programme planning to incorporate individual resident’s interests, abilities and needs (for groups and individuals)</td>
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<tr>
<td></td>
<td>Group preparation and facilitation skills</td>
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<td></td>
<td>Providing occupation focused individual interventions</td>
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<tr>
<td></td>
<td>Awareness and use of existing spaces within and around the facility</td>
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</tr>
<tr>
<td>Care staff</td>
<td>Level of residents engagement in daily care occupations, as currently completed by care staff</td>
<td>Increase the presence and quality of co-occupations by:</td>
<td>Individual residents have more opportunities for occupation, and experience increased control, participation, sense of achievement and life satisfaction</td>
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<tr>
<td></td>
<td>Current work practices in terms of facilitating or detracting from care staff engaging in activities with residents during &quot;down time&quot; or &quot;lounge duties&quot;</td>
<td>• Offering education sessions regarding the concepts and benefits of enabling occupation, co-occupations</td>
<td>Staff have knowledge and skills to implement co-occupations</td>
</tr>
<tr>
<td></td>
<td>Which individual staff members or clusters of staff demonstrate interest and skills in developing co-occupational practices</td>
<td>• Setting up a working party with key staff to increase staff and residents' experience of co-occupations</td>
<td>Staff may achieve more satisfaction, an increased sense of achievement and pleasure in their work</td>
</tr>
<tr>
<td></td>
<td>Care staff needs, expectations and occupational satisfaction</td>
<td>• Increasing scope of care staff routine tasks to include providing simple activities for residents</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Making recommendations for provision of resources to enable the above</td>
<td></td>
</tr>
<tr>
<td>Organisation</td>
<td>Evaluate resources, processes, policies, procedures etc, in terms of occupational outcomes for residents, related to the outcomes of all the preceding evaluations and assessments</td>
<td>Submit a proposal to senior staff and manager / management to promote an increase in occupational outcomes for residents (include financial benefits)</td>
<td>Increased awareness at all levels within the organisation of the importance of occupational opportunities and of creating an environment that provides opportunities/resources for participation</td>
</tr>
<tr>
<td></td>
<td>Identify risks associated with residents being more active</td>
<td>Make recommendations for including an occupational focus as an expected and required approach for care givers during the delivery of daily cares e.g. in care related policies and job descriptions</td>
<td>Increased knowledge and skills of care staff to engage residents in a greater variety of occupations and at greater frequency</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Prioritise the selection of focus areas as outlined in this table e.g. deciding to start with focusing specifically on the care staff</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Put plans and procedures in place to manage risks associated with residents being more active</td>
<td></td>
</tr>
</tbody>
</table>

**Table 1. Occupation focused approach to occupational therapy services in residential care – based on a mixed advisory / practitioner role. Continued.**
When people enter residential care, achieving functional improvements may come from addressing their occupational losses, stimulating engagement in activity, and providing a vibrant community (O’Sullivan & Hocking, 2006; Snowden & Fleming, 2008) than treating their medical conditions. As occupational therapists working with older adults have asserted over the decades, there is a need to focus on the individual’s remaining abilities and needs rather than disease and disability (Rogers, 1981). Engaging family/whanau in supporting ongoing participation in valued occupations is essential for some residents. A proportion of residents will benefit from the specialist skills and knowledge of an occupational therapist on an individual basis. This may help to increase their occupational performance or participation, well-being, life satisfaction and connection with their sense of self (Clark, 2000). Such interventions include assessing whether individual needs align with other residents’ needs, in order to make group / facility recommendations and ensure the best possible “Person–Environment-Occupation fit” (Law et al., 1996, p. 17).

Registered nurses and senior staff

In order to maximise the occupational therapist’s skills, knowledge and time, registered nursing staff and management need to be informed of the potential input from the occupational therapy service and its benefits to residents. In this instance, the first goal is to establish the extent of staff knowledge, and to ensure that referrals for specific occupational therapy interventions are appropriate. Knowledge development can be supported by introducing structured referral forms. Next, set up a communication system within the facility that will support efficient and appropriate discussion of resident needs in a multi-disciplinary team approach, since presence at convened multidisciplinary meetings is unlikely to occur within a contractual framework. Finally, put strategies in place to ensure there is effective follow up on recommendations made for individual residents.

Residents with similar occupational needs

In each facility, residents with similar needs can be identified. To some extent, residents are already ‘grouped’ according to the needs assessment which is done prior to admission, e.g. identified rest home, hospital, or secure dementia unit level of care. Within each of these service areas another aspect of needs assessment may be required, usually in terms of the level of support a resident needs (O’Sullivan, 2005). The emphasis is on grouping residents according to their interests and occupational histories. This is consistent with the Health and Disability Services Standards (Standards New Zealand, 2008), which state that planned activities should be “appropriate to their needs, age, culture and the setting” (p. 37). Such groupings may require a different approach from staff, a variety of activities or adaptations of activities, and various environments to ensure maximum occupational engagement and participation.

To achieve that, assessment focuses on identifying which residents fall into which group. A good record keeping system will support that information. The occupational therapist can then enhance staff knowledge by coaching activities staff to best meet the needs of the identified groups of residents, in terms of regular opportunities to engage in occupations that are of interest to the residents and within their capability. This is in keeping with the requirements of the Ministry of Health (2001).

Activity staff

Activities staff in a facility may vary significantly in their level of experience, skill, knowledge and attitudes (Dorrestein, 2006). The occupational therapist can supervise, educate and mentor activities staff so that residents receive a higher standard of input. Other areas of service delivery such as assessment, documentation, programme planning and implementation, individual and group skills need to be considered, with particular emphasis on occupational outcomes for residents.

Care staff

To give residents opportunities to use their abilities, the occupational therapy role focuses on several aspects of care staff interventions including daily occupations such as personal hygiene, dressing, and meals. The concept of co-occupation, described as care giving activities “that by their very nature, require more than one person’s involvement” (Zemke & Clark, 1996 p. 213), is useful. This term can equally and very appropriately be applied to the care-giving situation in residential care for older people, shifting caregivers’ thinking from doing things for residents, to doing things together. An additional challenge is to persuade care staff to create opportunities for occupation during less busy times of the day, and then encourage and support residents’ participation.

The organisation

Since the occupational therapist is contracted to the organisation, the organisation as a whole can be viewed as being a client in the occupational therapy process (Townsend et al., 1997). This entails evaluating and addressing the organisational policies and procedures, environmental conditions, and human resources from an occupational perspective, specifically in relation to increasing the occupational outcomes for residents. As a result, staff at all levels of the organisation will have an increased awareness, knowledge, and skills in relation to the importance of regularly engaging residents in a wide variety of occupations.

Summary

In this article the scope of an occupational therapy role in residential care settings for older people has been explored. The discussion drew on a variety of perspectives to highlight the complexity of this field of practice in New Zealand’s socio-political, economic, and employment context. The Canadian Model of Occupational Performance, the Model of Human Occupation, a health promotion framework and consultation models assisted the conceptualisation of ways in which occupational opportunities for residents in long term care facilities might be enhanced. The need for a multivariate approach to increase staff effectiveness in creating a residential care environment that is rich in occupational opportunities for residents was discussed. The role encompasses lines of inquiry and evaluation; the focus is
service implementation and occupational outcomes for residents. In effect staff members, and the organisation, can gain directly and indirectly from the knowledge and skills of an occupational therapist.

Acknowledgement
The information in this article was developed as part of the requirements for the Post Graduate Certificate in Health Science (Occupational Practice) at the Department of Occupational Science and Therapy, Auckland University of Technology (AUT).

References


The convergent validity of two sensory processing scales used with school–age children:  Comparing the Sensory Profile and the Sensory Processing Measure

Ted Brown, Ilona C. Morrison, and Karen Stagnitti

Abstract

Aim: To investigate the convergent validity between the Sensory Profile, the Sensory Profile School Companion, and the Home and Main Classroom Forms of the Sensory Processing Measure.

Method: Thirty mothers completed the Sensory Profile and the Sensory Processing Measure – Home Form on one child each. Nineteen teachers of the same children completed the Sensory Profile School Companion and the Sensory Processing Measure - Main Classroom Form.

Results: The Sensory Profile and the Sensory Processing Measure – Home Form were significantly correlated (rho=0.86, p<.01). The Sensory Profile School Companion and Sensory Processing Measure – Main Classroom Form were also significantly correlated (rho=.74, p<.01).

Conclusion: The two sets of sensory processing scales had moderate levels of convergent validity.

Key words
Child, occupational therapy, validity, Sensory Profile, Sensory Processing Measure

Reference

Sensory processing problems can often negatively impact a child’s occupational performance. For example, the limited range of foods a child will eat, sensitivity to certain types of clothing textures, low tolerance for noisy environments, and aversion to being hugged. Occupational therapists have a key role in assessing the sensory needs of children. Sensory processing scales used with school-age children include the Sensory Profile (Dunn, 1999), the Sensory Profile School Companion (SPSC) (Dunn, 2006), and the Sensory Processing Measure (SPM) (Miller–Kuhaneck, Henry, Glennon, & Mu, 2007; Parham, Ecker, Miller–Kuhaneck, Henry, & Glennon, 2007). These scales are all standardized parent–report, teacher–report, judgment–based questionnaires that require the respondent to complete a rating scale based on how frequently certain behaviours occur. For any standardized test, it important that a body of psychometric evidence is established, particularly studies completed by independent investigators, in addition to the studies completed by the original test authors (Anastasi & Urbina, 1997; Downing, 2003; Streiner & Norman, 1995). Since the scales under investigation are all relatively new, additional empirical studies documenting their reliability and validity are needed (Baranek, 2002; Goodwin, 2002; Kielhofner, 2006).

The purpose of this study is to examine the convergent validity of the Sensory Profile, the SPSC, and the Home and Main Classroom Forms of the SPM. The specific research questions are: i) what is the convergent validity of the SPM – Home Form...
and the Sensory Profile?; ii) what is the convergent validity of the SPM – Main Classroom Form and the SPSC?; and iii) what is the association between the ratings of mothers of children who complete the Sensory Profile and the SPM – Home Form and the ratings of teachers of the same children who complete the SPSC and the SPM – Main Classroom Form?

The Sensory Profile, the SPSC, and the SPM were all developed in the United States, but are used by therapists in New Zealand and Australia as well as other Western countries (Rodger, Brown, & Brown, 2006; Rodger, Brown, Brown, & Roever, 2006). Completing studies in a cross cultural context provides valuable data about the relevance, usability, and applicability of the scales (Brown, Leo, & Austin, 2008; Streiner & Norman, 1995). Information regarding convergent validity is currently lacking with the Sensory Profile, SPSC, and the SPM (Fairbank, 2005; Miller–Kuhaneck et al., 2007).

Literature review
Sensory processing is a neurological process that occurs in all of us. Sensory input from the environment and from the body itself provides information to the brain (Dunn, 2007). The brain organizes, integrates, synthesizes, and uses this information to understand experiences and organize appropriate responses. The processing of information allows individuals to respond automatically, efficiently, and comfortably in response to the specific sensory inputs received (Dunn, 2007; Yack, Aquilla, & Sutton, 2002). Sensory processing skills influence a child’s ability to perform everyday tasks and activities (occupations), and therefore they are used by occupational therapists for specific assessment, intervention, monitoring, and follow-up evaluation (Case-Smith, Richardson, & Schultz-Krohn, 2005; Yack et al., 2002).

Sensory processing disorder
Sometimes a child’s response to the sensory environment can have a negative impact on the successful engagement with and completion of his/her daily life occupations. Sensory processing disorders (SPD) “affects the way the brain interprets the information that comes in and the response that follows, causing emotional, motor, and other reactions that are inappropriate and extreme” (Bowyer & Cahill, 2009, p. 331). Reduced ability to play successfully with other children can be related to poor participation in sensory and motor play, from which cognitive and social skills emerge and develop (Bundy, 2002). The fear, anxiety, or discomfort experienced in everyday situations by children with sensory processing impairments can disrupt daily routines in the home environment (Parham & Mailloux, 2005). Furthermore, school environments may contain social and physical stimuli that cause these children distress (Burleigh, McIntosh, & Thompson, 2002). Challenges stemming from sensory processing disorders sometimes only become apparent once a child enters a day-care or school environment (Burleigh et al.). Sensory processing problems may even persist into adulthood, with related social, behavioural, and emotional difficulties (Kinnealey, Oliver, & Wilbarger, 1995).

Parham and Mailloux (2005) outlined five functional impairments associated with SPD. These include, decreased social participation and occupational engagement; decreased length, frequency, or complexity of adaptive responses (successful response to an environmental challenge); impaired self-confidence and or self-esteem; poor daily life skills and reduced family life; and diminished fine-, gross-, and sensory-motor skill development. SPD can negatively affect development and functional abilities in behavior, emotional, motor, and cognitive domains (Ahn et al., 2004). Children diagnosed with various conditions including Autism Spectrum Disorder, Asperger Syndrome, Attention Deficit Hyperactivity Disorder, Sensory Modulation Disorder, Developmental Coordination Disorder to name a few, are prone to SPD (Ahn et al.; Baranek, 2002; Dunn, 2006; Kern et al., 2007; Rebye & Stalker, 2008; Rogers, Hepburn, & Wehner, 2003). Occupational therapists working with children in these diagnostic groups, aim to promote and optimize their occupational performance and occupational development, therefore they need to assess and understand sensory processing.

Estimated rates of sensory processing disorders for children with developmental disabilities have been derived from reliable and valid survey results and are reported to be as high as 40% to 88% (Tomchek & Dunn, 2007). Among children without disabilities, estimates of the prevalence of sensory processing disorders based on clinical experience have ranged from 5% to 10% (Ahn et al., 2004). However, no prospective published data exists on the rate of sensory processing disorders in a typically developing population. Ahn et al. conducted one such study, to estimate sensory processing disorders in a typically developing population, using a parent-report survey screening instrument. This study found that 5.3% of their sample met criteria for SPD. These figures clearly indicate the importance of having instruments and scales that are valid and reliable when screening and assessing sensory processing issues.

Validity
The validity of a test or scale is gauged by comparing it to tests of the same concept or construct developed through other methods (Streiner & Norman, 1995). The convergent validity of an instrument or scale indicates the degree of consistency between measurements obtained by different approaches measuring the same trait (Anastasi & Urbina, 1997). For instance, to demonstrate the convergent validity of a test of reading skills, two sets of scores from different tests measuring the same reading ability would be compared. High correlations between the test scores would be evidence of a convergent validity between the two instruments. To estimate the degree to which any two scales are related to each other, a correlation coefficient is typically used (Anastasi & Urbina). That is, the patterns of inter correlations among the test scores are reviewed. Correlations between theoretically similar measures should be ‘high’ while correlations between theoretically dissimilar measures should be ‘low’ (Streiner & Norman, 1995). Thus, scores from the Sensory Profile, SPSC, and the SPM can be correlated since they claim to measure the same sensory processing constructs.
Method

A prospective quantitative research process was used for this study, since this design enabled the examination of the relationships between variables using numerical presentation of statistical analysis.

Participants

This study involved two groups of participants each recruited via convenience sampling in local school districts. Participants in the first group were mothers of a group of children aged five to ten years. The second group consisted of the classroom teachers of the same group of children. All the participants were city dwellers. The children who were the focus of the report did not have any known or suspected sensory processing problems and were typically developing. Typically developing children were included in the study to compare the sensory process constructs measured by the four scales as reported by mothers and teachers.

A total of 30 mothers took part in the study. The inclusion criteria included:

- having a child between the ages of five and ten years
- both parents’ having input to completing the Sensory Profile and the SPM – Home Form
- having a working knowledge of written English language.

Nineteen teachers took part in the study. The inclusion criteria for the teachers included:

- being the main classroom teacher of the child.

Table 1. Demographic information related to participants

<table>
<thead>
<tr>
<th>Parent participants (N=30)</th>
<th>N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>Female (mothers)</td>
<td>30 (100)</td>
</tr>
<tr>
<td>Age</td>
<td></td>
</tr>
<tr>
<td>18–25 years</td>
<td>2 (3.3)</td>
</tr>
<tr>
<td>26–35 years</td>
<td>7 (25.0)</td>
</tr>
<tr>
<td>36–45 years</td>
<td>17 (58.4)</td>
</tr>
<tr>
<td>46–55 years</td>
<td>3 (10.0)</td>
</tr>
<tr>
<td>56 + years</td>
<td>1 (3.3)</td>
</tr>
<tr>
<td>Marital status</td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>28 (93.4)</td>
</tr>
<tr>
<td>De facto / common–law</td>
<td>2 (6.6)</td>
</tr>
<tr>
<td>Single</td>
<td>0 (0.0)</td>
</tr>
<tr>
<td>Divorced/Separated</td>
<td>0 (0.0)</td>
</tr>
<tr>
<td>Time child resides in care</td>
<td></td>
</tr>
<tr>
<td>Full–time</td>
<td>30 (100.0)</td>
</tr>
<tr>
<td>Part–time</td>
<td>0 (0.0)</td>
</tr>
<tr>
<td>Geographical location of residence</td>
<td></td>
</tr>
<tr>
<td>Inner city</td>
<td>2 (6.6)</td>
</tr>
<tr>
<td>Suburban</td>
<td>11 (36.6)</td>
</tr>
<tr>
<td>Rural</td>
<td>17 (56.6)</td>
</tr>
</tbody>
</table>
Instruments
As mentioned previously, the instruments being tested include the Sensory Profile, the SPSC, the SPM – Home Form, and the SPM – Main Classroom Form. All the scales require the respondent to rate how frequently a behavior occurs using a Likert-type rating scale (e.g., Never, Occasionally, Frequently, Always).

Sensory Profile
The Sensory Profile (Dunn, 1999) measures a child’s sensory processing abilities and provides an overview of their effect on daily functioning. It is designed for children five to ten years of age. The 125 items on the questionnaire are divided into three main sections; Sensory Processing, Modulation and Behavioural and Emotional Responses (each of these sections are further divided for a total of 14 subscales). Sensory Processing is divided into six sections: Auditory, Visual, Vestibular, Touch, Multisensory and Oral. Modulation is composed of five areas: Sensory Processing Related to Endurance/Tone, Modulation Related to Body Position and Movement, Modulation of Movement Affecting Activity Level, Modulation of Sensory Input Affecting Emotional Responses and Modulation of Visual Input Affecting Emotional Responses and Activity Level. Behavioural and Emotional Responses are made up of Emotional/Social Responses, Behavioural Outcomes of Sensory Processing and Items Indicating Thresholds for Response. Scores for each of these scales are calculated.

Normative data was collected on 1,037 children without disabilities (524 girls and 510 boys; gender not reported on 3 year age level) between the ages of three and ten years (Dunn, 1999; Dunn & Westman, 1997). This standardization group was based on a North American population, ethnicity (uneven representation), socioeconomic status, and gender characteristics (Dunn, 1999; Vacca, 2005).

The reliability data reported in the Sensory Profile manual includes that of internal consistency using Cronbach’s alpha (Dunn, 1999). The subscale coefficients ranged from 0.47 to 0.90. In regards to validity, the manual provides preliminary evidence of both content and construct validity (Dunn). Content validity was supported by a literature review, expert review and a category analysis. Convergent and discriminant construct validity was demonstrated through comparison of the Sensory Profile and the School Function Assessment; however limitations of this comparison have been reported (Dunn; Fairbank, 2005; Vacca, 2005). Further validity studies have taken place with different diagnostic groups and the Sensory Profile is able to differentiate children diagnosed with Attention Deficit Hyperactivity Disorder, Asperger Syndrome, Pervasive Developmental Disorder, Fragile X Syndrome from children with typical development (Dunn, Myles, & Orr, 2002; Ermer & Dunn, 1998; Fairbank, 2005; Tomchek & Dunn, 2007; Watling et al., 2001). Documented evidence of criterion-related validity, predictive validity, and convergent validity are absent in the Sensory Profile manual and have not been reported in the literature.

Sensory Profile School Companion
The Sensory Profile School Companion (SPSC) (Dunn, 2006) provides a standardized assessment of a student’s sensory processing abilities and provides an indication of their association with the student’s functional performance in the classroom and school environments. It is designed for children of 5-10 years of age. The teacher who has routine contact with the student completes the questionnaire. The SPSC consists of 62 items, the items cover five domains: auditory, visual, movement touch, and classroom behaviors. Scale scores for each of these domains are calculated. The standardization sample included 700 children rated by 118 teachers. Sixty-two teachers rated 585 children without disabilities and 61 teachers rated 127 students with disabilities (Dunn, 2006). The reliability data reported in the SPSC manual included internal consistency using Cronbach’s alpha which ranged from 0.80 to 0.95, and test-retest coefficients from 0.80 to 0.95 (Dunn, 2006).

In terms of SPSC validity, content validity was established by having teachers rate the items they thought were relevant to school contexts. Construct validity was established through the completion of a principal component analysis of the items. The SPSC has moderate correlations with the Sensory Profile, but varying results were found across items. In relation to discriminant validity, the SPSC was able to differentiate students with Attention Deficit Hyperactivity Disorder, Asperger’s Syndrome, and Autism Spectrum Disorder from students without disabilities (Dunn, 2006). The manual also provides evidence of content validity, face validity, discriminant validity, and construct validity (Dunn, 2006). Evidence of criterion-related validity, predictive validity, concurrent validity, and convergent validity are absent in the SPSC manual and are not reported in the literature.

Sensory Processing Measure
The SPM assesses social participation, praxis, and sensory processing issues of children aged between 5-12 years (Parham, et al., 2007). The SPM promotes collaboration between parents and school personnel to identify sensory and environmental issues that may affect a child’s performance across home and school environments The SPM consists of three forms; the Home Form made up of 75 items completed by caregiver, the Main Classroom Form with 62 items completed by main classroom teacher, and School Environments Form completed by other school personnel (not used in this study) (Henry, Ecker, Glennon, & Herzberg, 2009). The SPM – Home Form and the SPM – Main Classroom Form were standardized on a sample of 1051 typically developing children aged between 5-12 years. Internal consistency and test-retest reliability data for the Home Form were reported as 0.77 to 0.95 and 0.94 to 0.98 respectively. For the main classroom form internal consistency scores ranged from 0.75 to 0.95 and test-retest estimates ranged from 0.95 to 0.98 (Parham, et al., 2007).

In regards to validity, content validity was established through use of expert review panels and factor analysis was used to provide evidence of SPM scale construct validity (Parham et al., 2007).
The SPM Home Form was found to be significantly correlated with the Sensory Profile, providing evidence of convergent validity (Parham et al., 2007). Discriminant validity was proven as both SPM – Home Form and the SPM – Main Classroom Form were able to differentiate between typical children and those with clinical disorders (Parham et al., 2007). There was no documented evidence of convergent validity.

Procedure
Ethical approval for the study was obtained from the Deakin University Human Research Ethics Committee. Mothers of the children registered their interest in participating after being approached by the researchers. A questionnaire package which included copies of the Sensory Profile and the SPM – Home Form was sent out along with a reply paid envelope. Snowball sampling was also used as a recruitment strategy among suitable parents. Eligible teacher participants were identified through contact details provided by the mothers. The teachers were sent a questionnaire package which included; copies of the SPSC and the SPM – Main Classroom Form, and a reply paid envelope. Of 30 teachers targeted only 19 returned the two completed sensory processing scales.

Data entry, management, and analysis
The data were analyzed using the Statistical Package for Social Sciences program (SPSS) version 15.0. Descriptive statistics were used for all demographic variables such as age, gender and geographical location. A frequency distribution analysis was used to calculate descriptive statistics and Spearman’s rho correlation coefficients for the convergent validity between the sensory processing scales. A Spearman’s rho correlation, a type of non-parametric statistic was used since the level of data generated by the Sensory Profile, the SPSC, the SPM –Home Form, and the SPM – Main Classroom Form are ordinal. Ordinal level data are measured based on the rank order of concepts / variables / order of importance rather than actual values. The actual distance between values is not known (disagree strongly, disagree, no opinion, agree, agree strongly).

For the convergent validity analysis, the scores of the SPM were reversed (1 was scored as 4, 2 was scored as 3, 3 was scored as 2, and 4 was scored as 1) to ensure scoring consistency with the Sensory Profile and the SPSC, as the scales use opposite rating scales. For instance, a low score on the Sensory Profile indicated sensory processing problems whereby a high score on the SPM indicated sensory processing issues.

Results
Demographic results
The majority of the mothers who took part in the study were in the 36 to 45 year age range (58.4%) and married (93.3%). The number of boys and girls involved in the study were almost equal and most of them attended Grade 2 at a publicly funded primary school. The majority of the teachers were female (94.7%) and had worked in the education system for more than six years. They were all employed in the publicly funded primary school system (see Table 1). There was a relatively even distribution of teachers across the age categories.

Sensory processing scale scores
Descriptive statistics of the Sensory Profile, the SPSC, and the SPM were calculated and are reported in Tables 2, 3, 4, and 5. It is important to note that the Sensory Profile and the SPSC use alternative rating scales to the SPM. The majority of participants scored highly on the Sensory Profile and the SPSC. The majority of participants scored low on the SPM – Home Form. Low scores were also noted on the SPM – Main Classroom Form.

The majority of participants scored highly on the Sensory Profile, with the lowest total scale score being 425 out of a possible 625. The mean total scale score rated by mothers was 542.83 (SD= 45.39) (see Table 2). The majority of participants scored low on the SPM – Home Form, with the highest total scale score being 116 out of a possible 300, and a mean total scale score of 90.63 (SD= 11.24) for mothers (see Table 3). High scores were also noted on the SPS Companion, with the lowest total scale score

| Table 2. Mean scores for the Sensory Profile scales completed by mothers (N=30) |
|-----------------|-----------------|-----------------|-----------------|
| Scale           | Mean (SD)       | Min  | Max  | Total possible |
| Sensory Profile (complete scale) | 542.83 (45.39) | 425  | 619  | 625            |
| Subscale A: Auditory Processing | 33.50 (4.53) | 24   | 39   | 40             |
| Subscale B: Visual Processing | 39.37 (3.83) | 30   | 45   | 45             |
| Subscale C: Vestibular Processing | 50.97 (3.36) | 42   | 55   | 55             |
| Subscale D: Touch Processing | 80.77 (7.93) | 57   | 90   | 90             |
| Subscale E: Multisensory Processing | 31.00 (2.88) | 24   | 35   | 35             |
| Subscale F: Oral Processing | 52.27 (7.65) | 32   | 60   | 60             |
| Subscale G: Endurance/Tone | 42.30 (4.76) | 26   | 45   | 45             |
| Subscale H: Body Position and Movement | 44.80 (3.99) | 33   | 50   | 50             |
| Subscale I: Affecting Activity Level | 24.97 (4.62) | 16   | 34   | 35             |
| Subscale J: Affecting Emotional Responses | 17.60 (1.92) | 14   | 20   | 20             |
| Subscale K: Visual Input Affecting | 16.77 (2.51) | 8    | 19   | 20             |
| Subscale L: Emotional/Social | 70.27 (9.84) | 42   | 85   | 85             |
| Subscale M: Behavioural Outcome | 24.33 (4.11) | 15   | 30   | 30             |
| Subscale N: Thresholds Response | 13.93 (1.36) | 10   | 15   | 15             |

Note. SD = standard deviation; Min = minimum; Max = maximum.
being 246 out of a possible 310, and a mean total scale score of 285.47 (SD = 19.29) (see Table 4). Low scores were also noted on the SPM – Main Classroom Form, with the highest total scale score being 87 out of a possible 248, and a mean total scale score of 72.79 (SD = 7.46) (see Table 5).

**Convergent validity results**

The convergent validity of the Sensory Profile and its fourteen subscales in relation to the SPM – Home Form and its eight subscales is presented in Table 6. This analysis uses the data obtained from the questionnaires completed by the mothers only. The Sensory Profile and the SPM – Home Form were significantly correlated with each other (rho = 0.86, p < .01). The majority of the Sensory Profile and the SPM – Home Form subscales were significantly correlated with each other. Significant subscale correlations ranged from 0.37 (p < .05) to 0.77 (p < .01).

Table 7 presents the convergent validity results of the SPSC and its five subscales in relation to the SPM – Main Classroom Form and its eight subscales. The SPSC and SPM – Main Classroom Form were also significantly correlated with each other (rho = 0.74, p < .01). Again, the majority of the SPSC and SPM – Main Classroom Form subscales were also significantly correlated with each other. Significant subscale correlations ranged from 0.36 (p < .05) to 0.74 (p < .01).

**Discussion**

Occupational therapists frequently assess the sensory needs of children using the Sensory Profile and the SPM. It is essential that the sensory processing scales used by therapists are valid. The purpose of this study was to investigate the convergent validity between the Sensory Profile, the SPSC, and the Home and Main Classroom Forms of the SPM. Specifically, the association between the ratings of mothers of children who complete the Sensory Profile and the SPM – Home Form and the ratings of teachers of the same children who complete the SPSC and the SPM – Main Classroom Form were investigated.

**Convergent validity**

The convergent validity of the Sensory Profile and the SPM - Home Form and the SPSC and the SPM - Main Classroom Form were calculated using Spearman’s rho correlation statistic. The results of the current study show a relatively high number of significant results, spread across a number of the total scale score and subscale variables of the four instruments. These results suggest a moderate

### Table 3. Mean scores for the Sensory Processing Measure – Home Form scales completed by mothers (N = 30)

<table>
<thead>
<tr>
<th>Scale</th>
<th>Mean (SD)</th>
<th>Min</th>
<th>Max</th>
<th>Total score possible</th>
</tr>
</thead>
<tbody>
<tr>
<td>SPM – Home Form (complete scale)</td>
<td>90.63 (11.24)</td>
<td>75</td>
<td>116</td>
<td>300</td>
</tr>
<tr>
<td>Subscale A: Social Participation</td>
<td>14.60 (3.77)</td>
<td>10</td>
<td>26</td>
<td>40</td>
</tr>
<tr>
<td>Subscale B: Vision</td>
<td>12.40 (1.73)</td>
<td>11</td>
<td>18</td>
<td>44</td>
</tr>
<tr>
<td>Subscale C: Hearing</td>
<td>9.20 (1.50)</td>
<td>6</td>
<td>13</td>
<td>32</td>
</tr>
<tr>
<td>Subscale D: Touch</td>
<td>13.43 (2.83)</td>
<td>11</td>
<td>21</td>
<td>44</td>
</tr>
<tr>
<td>Subscale E: Taste and Smell</td>
<td>5.87 (1.22)</td>
<td>5</td>
<td>10</td>
<td>20</td>
</tr>
<tr>
<td>Subscale F: Body Awareness</td>
<td>11.07 (1.68)</td>
<td>10</td>
<td>16</td>
<td>40</td>
</tr>
<tr>
<td>Subscale G: Balance and Motion</td>
<td>12.77 (2.54)</td>
<td>11</td>
<td>22</td>
<td>44</td>
</tr>
<tr>
<td>Subscale H: Planning and Ideas</td>
<td>11.30 (1.99)</td>
<td>9</td>
<td>16</td>
<td>36</td>
</tr>
</tbody>
</table>

Note. SPM = Sensory Processing Measure; SD = standard deviation; Min = minimum; Max = maximum.

### Table 4. Descriptive Statistics for the Sensory Profile School Companion (SPSC) scales (N = 19)

<table>
<thead>
<tr>
<th>Scale</th>
<th>Mean (SD)</th>
<th>Minimum</th>
<th>Maximum</th>
<th>Total score possible</th>
</tr>
</thead>
<tbody>
<tr>
<td>SPSC (complete scale)</td>
<td>285.47 (19.29)</td>
<td>246</td>
<td>310</td>
<td>310</td>
</tr>
<tr>
<td>Subscale A: Auditory</td>
<td>46.95 (2.82)</td>
<td>40</td>
<td>50</td>
<td>50</td>
</tr>
<tr>
<td>Subscale B: Visual</td>
<td>45.90 (6.34)</td>
<td>33</td>
<td>55</td>
<td>55</td>
</tr>
<tr>
<td>Subscale C: Movement</td>
<td>66.63 (4.13)</td>
<td>57</td>
<td>70</td>
<td>70</td>
</tr>
<tr>
<td>Subscale D: Touch</td>
<td>57.63 (2.89)</td>
<td>50</td>
<td>60</td>
<td>60</td>
</tr>
<tr>
<td>Subscale E: Behaviour</td>
<td>68.37 (5.36)</td>
<td>60</td>
<td>75</td>
<td>75</td>
</tr>
</tbody>
</table>

Note. SD = standard deviation; SPSC = Sensory Profile School Companion.

### Table 5. Descriptive Statistics for the Sensory Processing Measure – Main Classroom Form scales (N = 19)

<table>
<thead>
<tr>
<th>Scale</th>
<th>Mean (SD)</th>
<th>Minimum</th>
<th>Maximum</th>
<th>Total score possible</th>
</tr>
</thead>
<tbody>
<tr>
<td>SPM – Main Classroom Form (complete scale)</td>
<td>72.79 (7.46)</td>
<td>63</td>
<td>87</td>
<td>248</td>
</tr>
<tr>
<td>Subscale A: Social Participation</td>
<td>14.26 (2.81)</td>
<td>10</td>
<td>19</td>
<td>40</td>
</tr>
<tr>
<td>Subscale B: Vision</td>
<td>7.95 (0.78)</td>
<td>7</td>
<td>9</td>
<td>28</td>
</tr>
<tr>
<td>Subscale C: Hearing</td>
<td>7.53 (0.84)</td>
<td>7</td>
<td>9</td>
<td>28</td>
</tr>
<tr>
<td>Subscale D: Touch</td>
<td>8.95 (1.27)</td>
<td>8</td>
<td>11</td>
<td>32</td>
</tr>
<tr>
<td>Subscale E: Taste and Smell</td>
<td>4.63 (0.96)</td>
<td>4</td>
<td>7</td>
<td>16</td>
</tr>
<tr>
<td>Subscale F: Body Awareness</td>
<td>7.63 (0.68)</td>
<td>7</td>
<td>9</td>
<td>28</td>
</tr>
<tr>
<td>Subscale G: Balance and Motion</td>
<td>9.90 (1.15)</td>
<td>9</td>
<td>13</td>
<td>36</td>
</tr>
<tr>
<td>Subscale H: Planning and Ideas</td>
<td>11.95 (2.70)</td>
<td>10</td>
<td>20</td>
<td>40</td>
</tr>
</tbody>
</table>

Note. SPM = Sensory Processing Measure; SD = standard deviation.
Table 6. Convergent Validity of the *Sensory Profile* with the *Sensory Processing Measure - Home Form* completed by mothers (N=30)

<table>
<thead>
<tr>
<th>Scale</th>
<th>SPM – Home Form scales</th>
<th>Social Participation</th>
<th>Vision</th>
<th>Hearing</th>
<th>Touch</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sensory Profile total (complete scale)</td>
<td>0.863(**)</td>
<td>0.482(**)</td>
<td>0.636(**)</td>
<td>0.563(**)</td>
<td>0.736(**)</td>
</tr>
<tr>
<td>Auditory Processing</td>
<td>0.536(**)</td>
<td>0.384(*)</td>
<td>0.571(**)</td>
<td>0.513(**)</td>
<td>0.604(**)</td>
</tr>
<tr>
<td>Visual Processing</td>
<td>0.472(**)</td>
<td>0.222</td>
<td>0.505(**)</td>
<td>0.357</td>
<td>0.353</td>
</tr>
<tr>
<td>Vestibular Processing</td>
<td>0.625(**)</td>
<td>0.287</td>
<td>0.519(**)</td>
<td>0.320</td>
<td>0.448(*)</td>
</tr>
<tr>
<td>Touch Processing</td>
<td>0.669(**)</td>
<td>0.189</td>
<td>0.531(**)</td>
<td>0.452(*)</td>
<td>0.529(**)</td>
</tr>
<tr>
<td>Multisensory Processing</td>
<td>0.668(**)</td>
<td>0.349</td>
<td>0.515(**)</td>
<td>0.367(*)</td>
<td>0.515(**)</td>
</tr>
<tr>
<td>Oral Processing</td>
<td>0.682(**)</td>
<td>0.328</td>
<td>0.281</td>
<td>0.320</td>
<td>0.410(*)</td>
</tr>
<tr>
<td>Endurance/Tone</td>
<td>0.606(**)</td>
<td>0.509(**)</td>
<td>0.437(*)</td>
<td>0.555(**)</td>
<td>0.546(**)</td>
</tr>
<tr>
<td>Body Position and Movement</td>
<td>0.563(**)</td>
<td>0.254</td>
<td>0.559(**)</td>
<td>0.329</td>
<td>0.298</td>
</tr>
<tr>
<td>Affecting Activity Level</td>
<td>0.537(**)</td>
<td>0.353</td>
<td>0.549(**)</td>
<td>0.446(*)</td>
<td>0.509(**)</td>
</tr>
<tr>
<td>Sensory Input Affecting Emotional Responses</td>
<td>0.535(**)</td>
<td>0.456(*)</td>
<td>0.295</td>
<td>0.262</td>
<td>0.417(*)</td>
</tr>
<tr>
<td>Visual Input Affecting Emotional Responses and Activity Level</td>
<td>0.631(**)</td>
<td>0.326</td>
<td>0.390(*)</td>
<td>0.221</td>
<td>0.442(*)</td>
</tr>
<tr>
<td>Emotional/Social Responses</td>
<td>0.659(**)</td>
<td>0.505(**)</td>
<td>0.454(*)</td>
<td>0.498(**)</td>
<td>0.554(**)</td>
</tr>
<tr>
<td>Behavioural Outcomes</td>
<td>0.558(**)</td>
<td>0.480(**)</td>
<td>0.516(**)</td>
<td>0.462(*)</td>
<td>0.517(**)</td>
</tr>
<tr>
<td>Thresholds Response</td>
<td>0.558(**)</td>
<td>0.149</td>
<td>0.391(*)</td>
<td>0.230</td>
<td>0.376(*)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Scale</th>
<th>SPM – Home Form scales</th>
<th>Taste &amp; Smell</th>
<th>Body Awareness</th>
<th>Balance &amp; Motion</th>
<th>Planning &amp; Ideas</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sensory Profile total (complete scale)</td>
<td>0.629(**)</td>
<td>0.722(**)</td>
<td>0.527(**)</td>
<td>0.609(**)</td>
<td></td>
</tr>
<tr>
<td>Auditory Processing</td>
<td>0.295</td>
<td>0.362(*)</td>
<td>0.182</td>
<td>0.392(*)</td>
<td></td>
</tr>
<tr>
<td>Visual Processing</td>
<td>0.159</td>
<td>0.592(**)</td>
<td>0.157</td>
<td>0.391(*)</td>
<td></td>
</tr>
<tr>
<td>Vestibular Processing</td>
<td>0.373(*)</td>
<td>0.419(*)</td>
<td>0.429(*)</td>
<td>0.498(**)</td>
<td></td>
</tr>
<tr>
<td>Touch Processing</td>
<td>0.736(**)</td>
<td>0.576(**)</td>
<td>0.442(*)</td>
<td>0.442(*)</td>
<td></td>
</tr>
<tr>
<td>Multisensory Processing</td>
<td>0.406(*)</td>
<td>0.487(**)</td>
<td>0.510(**)</td>
<td>0.609(**)</td>
<td></td>
</tr>
<tr>
<td>Oral Processing</td>
<td>0.318</td>
<td>0.768(**)</td>
<td>0.503(**)</td>
<td>0.460(*)</td>
<td></td>
</tr>
<tr>
<td>Endurance/Tone</td>
<td>0.589(**)</td>
<td>0.425(*)</td>
<td>0.263</td>
<td>0.397(*)</td>
<td></td>
</tr>
<tr>
<td>Body Position and Movement</td>
<td>0.477(**)</td>
<td>0.413(*)</td>
<td>0.336</td>
<td>0.357</td>
<td></td>
</tr>
<tr>
<td>Affecting Activity Level</td>
<td>0.368(*)</td>
<td>0.450(*)</td>
<td>0.360</td>
<td>0.289</td>
<td></td>
</tr>
<tr>
<td>Sensory Input Affecting Emotional Responses</td>
<td>0.351</td>
<td>0.459(*)</td>
<td>0.313</td>
<td>0.288</td>
<td></td>
</tr>
<tr>
<td>Visual Input Affecting Emotional Responses and Activity Level</td>
<td>0.300</td>
<td>0.447(*)</td>
<td>0.485(**)</td>
<td>0.589(**)</td>
<td></td>
</tr>
<tr>
<td>Emotional/Social Responses</td>
<td>0.542(**)</td>
<td>0.458(*)</td>
<td>0.481(**)</td>
<td>0.461(*)</td>
<td></td>
</tr>
<tr>
<td>Behavioural Outcomes</td>
<td>0.359</td>
<td>0.333</td>
<td>0.318</td>
<td>0.464(**)</td>
<td></td>
</tr>
<tr>
<td>Thresholds Response</td>
<td>0.345</td>
<td>0.432(*)</td>
<td>0.429(*)</td>
<td>0.591(**)</td>
<td></td>
</tr>
</tbody>
</table>

Note. SPM = *Sensory Processing Measure*. *Correlation is significant at the p < .05. **Correlation is significant at the ** p < .01.
level of convergent validity between the Sensory Profile and the SPM - Home Form and between the SPSC and the SPM - Main Classroom Form. This provides occupational therapists with information about the validity of these sensory processing instruments.

The Sensory Profile and the SPM – Home Form were significantly correlated with each other with a coefficient of $\rho=0.86$ ($p<.01$). The majority of the Sensory Profile and the SPM – Home Form subscales were also significantly correlated with each other with coefficients ranging from 0.37 ($p<.05$) to 0.77 ($p<.01$). Similarly, the SPSC and SPM – Main Classroom Form were also significantly correlated with each other with a slightly lower coefficient of $\rho=0.74$ ($p<.01$). Again, the majority of the Sensory Profile and SPM – Main Classroom Form subscales were also significantly correlated with each other with coefficients ranging from 0.36 ($p<.05$) to 0.74 ($p<.01$).

Miller-Kuhaneck, Henry, and Glennon (2007) reported the results of a concurrent validity study correlating the SPM – Home Form with the Sensory Profile. The sample consisted of 182 children (137 boys, 45 girls) with an age range of 5 to 13 years. It was noted that the Sensory Profile Auditory, Visual, Vestibular, and Touch Processing subscales all significantly correlated with the SPM – Home Form subscales that represented content-similar sensory systems. "In sum, the SPM Home Form scale scores show the expected strong and consistent relationships with the scores of the Sensory Profile, a measure of children's sensory processing function" (Miller-Kuhaneck, Henry, & Glennon, 2007, p. 71).

Both sets of results showed that the Auditory, Visual, Vestibular, and Touch subscales of the Sensory Profile and the SPSC significantly correlated with the corresponding content-similar subscales on the SPM - Home Form and the SPM - Main Classroom Form. Both also showed that the SPM Planning and Ideas and Social Participation subscales on SPM - Home Form and SPM - Main Classroom Form were significantly related to the respective Sensory Profile Behavioural Outcomes subscale and the SPSC Behaviour subscale.

The convergent validity of these sensory processing assessments is not reported in the test manuals nor published in the literature therefore direct comparisons to any other published results cannot be made. However, Parham et al. (2007) as noted in the SPM manual did investigate construct validity (using convergent validity). This was done using the SPM – Home Form and the Sensory Profile with a sample of 182 children. Although Parham et al. did not report the data analysis method used, the results presented in the SPM manual are similar to those of the convergent validity shown in the current study. The lack of any investigation into the convergent validity of these assessments makes the results of the current study unique and timely. Parham et al. stated that convergent validity studies employing the SPM – Main Classroom Form and SPSC are an important area for future research, as it will constructively build on the current evidence base about the SPM.

It is important to note that although significant correlations within the convergent validity results may seem weak or moderate, Streiner and Norman (1995) suggested that correlations among measures of the same attribute should fall between 0.4 and 0.8. The majority of significant correlations found in this study were in this range which indicates the scales do exhibit a reasonable degree of convergent validity. Streiner and Norman argued that very high correlations above the stated range are not particularly desirable as this would imply that the tests measure almost exactly the same constructs in which case there is no need for separate tests. Consequently, a correlation below 0.4 indicates the reliability of one of the measures is low, or that they are measuring different phenomena (Streiner & Norman). This is particularly relevant to correlations purporting to measure the

### Table 7. Convergent Validity of the Sensory Profile School Companion with the Sensory Processing Measure - Main Classroom Form (N=19)

<table>
<thead>
<tr>
<th>Scale</th>
<th>Sensory Profile School Companion scales</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total SPSC</td>
</tr>
<tr>
<td>SPM - Main Classroom Form (total complete scale)</td>
<td>0.743(**)</td>
</tr>
<tr>
<td>Social Participation</td>
<td>0.533(*)</td>
</tr>
<tr>
<td>Vision</td>
<td>0.608(**)</td>
</tr>
<tr>
<td>Hearing</td>
<td>0.365</td>
</tr>
<tr>
<td>Touch</td>
<td>0.636(**)</td>
</tr>
<tr>
<td>Taste and Smell</td>
<td>0.332</td>
</tr>
<tr>
<td>Body Awareness</td>
<td>0.470(*)</td>
</tr>
<tr>
<td>Balance and Motion</td>
<td>0.186</td>
</tr>
<tr>
<td>Planning and Ideas</td>
<td>0.716(**)</td>
</tr>
</tbody>
</table>

Note. SPM = Sensory Processing Measure; SPSC = Sensory Profile School Companion. *Correlation is significant at the p < .05. ** Correlation is significant at the ** p < .01.
same constructs. However, the small size and the high scoring participants of the sample in this study must be considered influential factors to the results of this study.

**Study limitations and suggestions for future research**

There were a number of limitations to the study. Of significance was the small number of participants recruited via convenience sampling. It is possible that participants volunteered to take part in this study as they had concerns regarding their child’s health and in particular their child’s sensory processing, possibly resulting in a sample with a higher percentage of sensory issues than normally reflected in the population. Also, as the sensory processing scales under scrutiny were developed and standardized in the United States of America, there is the possibility of cultural bias in relation to the respondents completing the forms. Conversely, this may be minimal since the Sensory Profile has been used extensively by pediatric occupational therapists in New Zealand and Australia for the past decade.

It is suggested that similar studies could be undertaken with larger, more heterogeneous samples, from larger and more varied geographical areas. Test scores could be analyzed using alternate forms of validity approaches. Studies could involve participants who have some form of impairment. The statistical analysis based on scores achieved by such a sample groups could then be compared to the results of this study. Similar reliability studies could also be completed in other cross-cultural settings.

**Conclusion**

This study was designed to investigate the convergent validity of the Sensory Profile and the SPM – Home Form and the SPSC and the SPM – Main Classroom Form. The Sensory Profile and the SPM – Home Form as well as the SPSC and the SPM – Main Classroom Form were found to be moderately correlated with each other. This suggests that the scales are measuring comparable sensory processing constructs. The findings from this study contribute to the psychometric body of knowledge related to these four sensory processing scales, as well as providing therapists with a greater understanding of the scales’ reliability and validity properties.

**Key points**

1. The Sensory Profile and Sensory Processing Measure – Home Form have moderate levels of convergent validity.
2. The Sensory Profile School Companion and the Sensory Processing Measure – Main Classroom Form exhibit moderate levels of convergent validity.
3. The findings of this study provide therapists who use these scales with a greater understanding of the scales’ validity properties as well as the association between the sensory processing ratings of mothers and classroom teachers of the same child.

**Acknowledgements**

Financial support for this study in the form of a research grant from OT Australia, Victoria is gratefully acknowledged. The parents and teachers who volunteered their time and input to complete the sensory processing questionnaires are also thanked.

**References**


Healing through story telling: An integrated approach for children experiencing grief and loss

Rowena Scaletti and Clare Hocking

Abstract

Stories convey complex meanings and facilitate understanding of human experience. This article presents a focused story telling approach to elicit, develop and share children's stories of grief and loss. Using an illustrative case study, it describes an integrated therapeutic approach based in familiar childhood occupations of constructing scenes using sand and objects, interacting with peers, and working with a therapist to write and illustrate the child's own story. The approach draws on the first author's many years of clinical experience and international evidence of the therapeutic power of narrative approaches, sand tray therapy and bereavement groups for children.

Key words
Child mental health, story writing, narrative, sandtray therapy, grief.

Reference

For centuries stories have been used to record history, as well as impart meaning and assist understanding within a cultural context. Story telling is an indirect, cross-cultural method of communication which may be employed within the therapeutic setting to assist problem resolution (Fazio, 2008). Many therapeutic approaches use stories and storytelling (Boik & Goodwin, 2000; Clark, Ennevor & Richardson, 1996; Geldard & Geldard, 2001; Ziegler, 1992), and therapists working with children have combined storytelling, story making, play and art to facilitate communication since the 1980s (Hanney & Kozlowska, 2002; Remotigue-Ano, 1980). The use of narrative methods with children with psychosocial and mental health needs has been described as both a strength-oriented, child-centred approach and a collaborative means of respecting children as experts in their own lives (Bennett, 2008; Hanney & Kozlowska, 2002).

Occupational therapists employ stories as a therapeutic medium with diverse populations, assisting adults to resolve anxiety and depression (Gunnarsson, Jansson & Eklund, 2006) and older adults to adjust to devastating injuries (Kivnick, Stoffel & Hanlon, 2003). Using creative media and storytelling to help children address psychosocial issues is endorsed in the occupational therapy literature as a means of supporting children to tell their story of grief and loss, eliciting their interpretation of events (Fazio, 2008) and assisting them to make sense of the experience. Endorsing that approach, Milliken, Goodman, Bazyk and Flynn (2007) cite the truism ‘time doesn’t heal – actions do’. They describe participation in meaningful occupation as “uniquely capable of being a catalyst in the healing process” (p. 82) and a medium through which occupational therapists empower people “to discover meaning and significance in life” (p. 82).

There are multiple ways in which to use stories with children, including the involvement of a child in constructing a story of his or her own (Fazio, 2008; Jeffreys, 2005). To inform that work, occupational therapists have drawn on the work of counsellors, psychologists and philosophers. In addition, Clark, Ennevor and Richardson's (1996) concepts of occupational storytelling and story making is commonly invoked to explain how people “make sense of their illness and regain control over their occupational lives” (Wright-St. Clair, 2003, p. 48). This approach is often combined with the process of having clients tell their story and
envisage possibilities for the future (Gunnarsson et al., 2006; Kivnic et al., 2003).

This paper demonstrates the use of a storied approach to assist children who have experienced emotional trauma. The therapeutic approach described involves the integrated use of sandtray therapy, a peer group and story book creation. An illustrative case example of a girl commencing her healing journey from grief is provided. Emily's story is not based on a single case, but rather extrapolated from the first author's years of practise. While the necessity of a parallel programme for families is briefly discussed, it is not fully explored. The intention of this paper is to present a concise, focused, descriptive approach to change which may prove useful to other therapists working with children.

An occupational approach

The occupational approach we describe has its theoretical roots in narrative or storytelling. Narratives reflect cultural meanings and convey rich personal details. Stories, in particular, have been used as a therapeutic medium “to teach, to comprehend, to influence and to develop self-understanding as well as understanding of our unique social worlds” (Saarni, 1999, p. 20). Narrative therapy is underpinned by a constructivist worldview, which holds that the understandings people form about the world are not fixed; but rather they can be revised as new information becomes available (Geldard & Geldard, 2001). Children’s stories provide a window on how they construct their understanding of the complex events that affect them and how they think about and respond to those events (Saarni, 1991). There is accumulating evidence of the efficacy of narrative approaches with children (Bennett, 2008). Also present is an expectation that by understanding the way children view events and circumstances affecting them, therapists can then enable the adults who care for children to understand their grief responses and support them (Jeffreys, 2005).

While there are readily accessible resources to assist families to support children experiencing grief and loss (Heaney, 2002, 2004; Perkins, 2007; Sorenson, 2008), the occupational approach we present is supported by the professional literature and research evidence. It commences with sandtray therapy to elicit the child’s story, followed by validation of the child’s story in peer group therapy and making it into an illustrated storybook to take home. Like other therapeutic approaches for children with emotional issues, this three-pronged approach is a process through which children can experiment with ideas and feelings in a safe environment, as they explore, understand and accept their experiences (Robson, 2008).

Creating a story in the sandtray

Sandtray, a non-verbal projective modality, is one approach recommended to assist children to externalise their grief (Jeffreys, 2005). Sandtray work is an established therapeutic approach (Zarzaur, 2004) in which children are invited to select from a range of miniature figures and objects to construct or perhaps play out what is troubling them (Taylor, 2009). While Jungian analysts have employed psychoanalytic frameworks to analyse clients’ sandtray creations, the current trend is to dispense with theory driven interpretations (Boik & Goodwin, 2000). Accordingly the intent in the occupational approach we describe is to use the sandtray to ground the child in the present moment by telling a story using objects placed in the tray. When the child sits back and does no more, indicating that the sandtray is complete, open-ended questions can be asked such as, “Tell me about this part here” (indicating with a small sweep of the hand), and “What happened next?” Asking externalising questions (Bennett, 2008) to prompt children to explain what they have created in their own terms provides a transition from a non-verbal to verbal state (Taylor, 2009). While other play therapies may prove equally useful sand is a familiar multisensory medium which, together with the objects provided, can be used to represent people, places and events (Biok & Goodwin, 2000; Flahive & Ray, 2007; Webber & Mascari, 2008). As such, sandtrays are a safe place to express disturbing feelings.

The therapeutic potential of sandtrays was first recognised in the 1920s, by a child psychiatrist who was looking for “a medium that would be attractive to children and provide a means through which the observer and the child communicate” (Boik & Goodwin, 2000, p. 6). Our choice to begin the therapeutic process with a sandtray is because children both conceptualise possibilities through play activities (Fazio, 2008) and reveal their concerns, such as believing that they were the cause of death or illness (Jeffreys, 2005). Play is particularly useful with younger children and pre-adolescents who are less able to find words to adequately describe feelings associated with the trauma of grief and loss (Milliken et al., 2007; Shen & Armstrong, 2008) and those who are resistant or fearful (Webber & Armstrong, 2008). As Sorensen (2008) wrote, “For children to overcome their feelings of grief, however insignificant they may seem to adults, a vehicle is needed to express that loss through play, through art, and through stories” (p. 17).

Sandtray therapy has been described as humanistic, meaning that it rests on the understanding that children are social beings who have a need to belong and an inherent drive to develop their own potential (Shen & Armstrong, 2008; The Sandtray Therapy Institute, 2009; Webber & Mascari, 2008). There is some evidence that sandtray therapy is effective in addressing disruptive classroom behaviours arising from distressing life events (Flahive & Ray, 2007; Zarzaur, 2004). Group sandtray therapy has also been shown to be effective in improving the self-esteem of young adolescent girls from different cultural backgrounds (Shen & Armstrong, 2008).

Validating the story in a peer group

In peer group therapy, children coping with similar issues come together to interact, observe and listen to each other, reinforce each others’ skills and insights, and give and receive feedback about each others’ behaviour and thoughts. Bereavement groups for children have a long history in psychotherapy, and there is evidence of the effectiveness of therapeutic groups for children with clinical depression (Moore & Carr, 2002) and bereavement groups (Tonkins & Lambert, 1996).
Bereavement groups have been described as providing a safe venue to openly discuss feelings of sadness, anger, guilt and regret, and as helping grieving children to feel less isolated by showing that their feelings are normal (Jeffreys, 2005; Tonkins & Lambert, 1996). When children come together as a group to engage in creative activities, such as storytelling, they share their experiences and interpret the social and cultural appropriateness of the actions described (Fazio, 2008). In the process, they modify their opinions, attitudes and beliefs, experiment with new behaviours in a safe environment, gain confidence and change the ways they feel and behave (Geldard & Geldard, 2001; Milliken et al., 2007; Natter, 2005; Tonkins & Lambert, 1996).

Making a storybook
Concurrent with the peer group, one or both parents/caregivers and the therapist work individually with the child to make and illustrate a book recording the story that emerged in the sandtray. Capturing children's own stories and drawings in a book enables them to ‘see’ and ‘hear’ the story over and over again, remembering important details, asking questions and coming to understand their experiences and feelings. Individualised storybooks have a long history, having been used to prepare children for adoption in the 1950s, and more recently to assist developmentally delayed children to gain a sense of their life history and identity (Hanney & Kozlowska, 2002). In the 1970s, techniques combining storytelling and drawing were used to establish rapport with children reluctant to discuss their experiences, as well as evaluate their psychological and emotional status.

Two distinct approaches emerged in the 1990s. One involves helping individuals to ‘re-author’ their lives by reworking their story to offer a better solution or cast the main character in more heroic terms (Hanney & Kozlowska, 2002; Oaklander, 1998). The other approach “aims to help the child and family to tell their story as it was” (Hanney & Kozlowska, p. 43), so that semantic meaning can be attached to the events. Feelings associated with what happened can be considered and resolution of past trauma can occur. This is the approach used in the occupational process described here.

Capturing and illustrating a narrative which has already been built up in previous therapy sessions is distinct from the approach employed by some art therapists and psychiatrists. There, structured or informal art tasks may be used as an assessment tool or to elicit information about events and family interaction (Hanney & Kozlowska, 2002). It is also more personalised than having children reading published books about grief and loss (Jeffreys, 2005), or reading stories containing a moral or solution to them (Tonkins & Lambert, 1996), and more child-centred than having the therapist write a personalised storybook to read to children, as others have described (Zeigler, 1992).

Introducing Emily
Emily was an 8 year old girl referred following the death of her father in a motor vehicle accident. She presented with feelings of anger, sadness and some out-of-control behaviour especially at school. School refusal, withdrawal from her family, feeling sick and wanting to stay in bed were all part of the pattern of presenting behaviour. Further enquiry elicited information about problems at school including disruptive behaviour and difficulty concentrating in class. She became increasingly negative towards her school work, something she had previously enjoyed. Like many other children affected by grief (Moore & Carr, 2002), signs of agitation, irritability and anxiety also started to emerge, which impacted on Emily’s social networks. Other symptoms often observed among children dealing with grief are destruction of property, temper tantrums, self punishment, sleep disturbances, wandering or running away to search for the person who had died, blaming the surviving parent, or clinging to adults (Jeffreys, 2005; Milliken et al., 2007; Moore & Carr, 2002).

The “rippling effects of primary loss” bring with them a shift in the balance of family relationships (Jeffreys, 2005, p. 65). Emily's family, who were also coping with the death of a family member, were unsure how to help her. Children need to be heard. In order to achieve this, a meeting with Emily and her extended family was arranged to gain an understanding of the family needs which would inform subsequent goal setting. The meeting was also an essential first step in developing rapport between the child, family and therapist prior to commencing therapy. At the first appointment Emily’s mother spoke about the accident. She described the subsequent impact on the family, but especially the effect on Emily who still talked about her father as if he would be home soon. It was agreed that the therapist would see Emily alone to understand the story from her perspective.

Manifestations of internalised and externalised behaviour in children are believed to reflect the intensity of the problem (Flahive & Ray, 2007). Therefore, all of Emily’s reported and observed behaviours were documented as a base-line for comparisons. As a simple measure of change, the prime behaviours of school refusal, anger and withdrawal from social networks were rated on a scale from 1-5 (1 being low, 5 being high). However, if more formal measures of change are preferred, Flahive and Ray (2007, pp. 368-370) provide a comprehensive range.

Emily’s sandtray
It was suggested to Emily that she make a story about Dad in the sand from the available objects. Leaving choices with the child will bring into focus what troubles the child, not necessarily how the adults perceive the problem (Bennett, 2008). Healing frequently arises from and is strengthened through detail. The sandtray was kept intact between appointments for Emily to alone to understand the story from her perspective.

Using sandtray as the first medium, Emily developed a story using various objects (Boik & Goodwin, 2000; The Sandtray Therapy Institute, 2009; Webber & Mascari, 2008). Through this approach Emily gained an increase in emotional competence evidenced in her capacity for adaptive coping (Saarni, 1999). Over the course of three appointments, she gained sufficient understanding and meaning of her experiences to create an oral story.

At this point Emily was referred to a peer group for four sessions.
This provided a forum to speak of her experiences with similarly aged children who were also coping with grief. Concurrent with the broadening of the therapy focus, Emily’s mother was also invited to join her daughter in a story writing process. Her role was twofold; to understand and support Emily in her healing process and to find within her daughter’s story some healing for herself. Under Emily’s instruction the therapist wrote the story down. After several appointments and much revision Emily chose to write a story about a girl called Rose.

**Emily’s story**

Once upon a time there was a girl called Rose who lived with her Mum and Dad in a white house with a green roof. One day Nana and Granddad came. It was very early. Rose heard them talking with Mum. Then it went very quiet. Rose slid out of bed, careful not to stand on the squeaky floorboard. Tip-toeing out, she saw Mum at the table bent over a cup of tea. Mum was crying.

Rose felt sick inside, like the time Mum tucked her into bed with an extra blanket. But no-one noticed her now. She crept over to the sofa and tried to be small. She scrunched back into the corner worrying that her tummy would never feel happy again.

Rose heard Uncle John’s car on the drive. He came in and looked around. He spoke to Nana and Granddad. Her tummy was suddenly full of sharp, hot arrows. Her head hurt, her eyes had prickles in them. Uncle John came over to Rose, lifted her on to his knee. He looked different somehow, like he had eaten something nasty. He held her tight and said, “Rose, there’s been a bad accident. Dad’s not coming home.”

Later that week mum talked with Rose. She said gently, “Tomorrow we are all going to the funeral to remember Dad.” Mum tried to explain but Rose didn’t really understand. She just nodded. She thought, I’ll ask Nana to explain all this stuff about dying. It’s too hard to know. It was too scary to ask Mum because she cried a lot.

“Draw some pictures for Dad to take with him,” Nana suggested. Rose used all the colours Dad liked best: green and purple and orange. She wrote “To Dad, with lots of love from Rose.”

The man at the funeral told everyone about the big truck that hit Dad’s car. Wearing Dad’s warm blue jersey, Rose sat still and stiff between Mum and Nana. Granddad watched over them. Uncle John talked about Dad. Lots of people cried, especially when Dad’s coffin was put into the hole in the ground. Nana whispered, “Throw these flowers down to Dad.”

Rose watched the petals float down to Dad. She remembered the times Dad would take her to the park. “Flowers are nature’s presents for us to enjoy,” said Dad’s voice inside her head. Rose shivered all over. Mum gave her a big squeeze hug.

One day, soon after Dad’s funeral, Rose ran all the way home from school. She ran so fast her face got all red. “I don’t want to go back to school,” Rose shouted. “People stare at me.” She started to cry. I’ll pretend I’m sick she thought. Her tummy hurt. There was a big black hole with slimy sides inside her. Rose raced into her bedroom and slammed the door.

Rose heard Mum and Nana talking outside her bedroom. “She won’t go to school”. That was Mum. “Perhaps we should get some help”. That was Nana. “I know,” Mum said, “I’ll phone the doctor. She will know of people who can help children.”

Later, Rose told her therapy group what had happened at school. “The teacher was reading a story to us about Mike. He was a scruffy sort of dog who got frightened by fireworks. He ran out onto the road and was hit by a car.” Rose stopped, taking lots of breaths to stop her insides, and outsides, shaking. She stood up. “I’ll show you what I did. My head felt so tight and hot I thought it would melt. I felt as though I couldn’t breathe properly. I screamed and screamed, running around the room bumping into desks and stuff. I was shouting and crying.” Rose paused from her running and shouting saying quietly, “I don’t remember everything, but the teacher told Mum all about it.”

The therapist asked the other children if they knew about this sort of stuff. They talked and drew pictures about sad things that had happened to them. Rose still didn’t understand why she was so frightened when Mike was hit by the car. The therapist spoke to the group. “Sometimes it takes a while. It’s like this for a lot of children.”

On the last day of term Rose went to school thinking about her therapy group. She noticed the new girl sitting alone, crying. Rose sat down beside her and touched her arm. “I know what it’s like to be sad,” she said softly. “My Dad died this year.” The girl brushed her hair out of her eyes. “My Nana is in hospital. She’s very sick.”

Rose told the girl about her therapy group. They talked and talked, sharing their stories about being scared and angry. As they walked back to class together Rose remembered her therapist saying, “Whenever you help someone else, you help yourself.”

“I shall tell all of this to Mum when I get home,” thought Rose.

**Emily and her peer group**

As Emily went into the group room she felt very anxious despite knowing her mother was waiting for her. The therapist, Jill, had arranged a picnic afternoon tea with drinks and biscuits and Emily sat down on the mat with the other children. In answer to Jill’s question everyone said their name and the names of the people living with them. Jill explained they did not have to talk about scary feelings; they would be making pictures, paintings, puppets, and playing games. When it was time to finish Jill asked...
them all to sit in a circle to say goodbye until the next group. “You know Mum,” Emily said later, “I found out that everyone knew someone who had died. It happens to lots of people. Everyone had feelings like mine. I never knew that before.”

**Emily’s storybook**

Emily and her mother decided to make a book (Gunnarsson et al., 2006; Zeigler, 1992). The pages on which the therapist had typed the story were assembled and on the opposite pages Emily drew pictures (Remotigue-Ano, 1980). Some drawings were coloured in black, some in the colours that Dad liked. When it came time to draw Dad’s funeral Emily cried and cried. Her mother, who by this time was becoming her daughter’s primary therapist, reassured her that crying was best.

Emily decided to take her book home to read to her teddy bear, Patches, so called because he was her Dad’s old teddy bear which her Nana had often mended. Patches sat up in bed with Emily and her mother heard the story being read over and over again. Emily explained to Patches how Dad was not coming home but that they could still talk to him. Emily also wondered if other children would like to read her story. Through the use of projective storytelling, Emily started her journey of acceptance and understanding.

**Conclusion**

Many children act out their feelings and emotions rather than discuss them with family. This may be due to their developmental and/or emotional age, their family’s grief which may act as a barrier, the culture within the family or a combination of all three. The occupational therapist’s goal is to harness the power of occupation to make it possible for children to express their feelings within their family context. Informed by understanding of occupational storytelling, the therapist encourages children with psychosocial needs to formulate and share their story first with the therapist, and then with peers and family. The process of telling their story from their perspective helps children understand their experiences. Capturing their story in an illustrated book allows children to repeatedly retell the story, to real or imaginary audiences, and to integrate the feelings that arise. Accordingly, behavioural manifestations of grief and anger decrease as children develop increased occupational competence, which is observed at home, at school and in peer interactions.

**Limitations and implications for practice and research**

By necessity, both the ways children respond to grief and the occupational approach to narrative therapy that have been described, draw primarily on overseas literature. One limitation of doing so is that the ideas and experiences presented were not developed or honed in New Zealand’s bi-cultural context. Therapists guided by our discussion will need to carefully consider contextual influences in their application and adaptation of these ideas. An additional limitation is that the paper does not include an actual case report, as neither author is currently practising in this area. Case reports, such as those previously published by Christie (2007) and Scaletti (2003), suggest what is possible by providing evidence about the range of interventions that have been used with similar clients and the outcomes achieved (Tickle-Degnen & Bedell, 2003). Nonetheless, the discussion has value in supporting clinical reasoning by synthesizing current research findings with the first author’s practice experience to describe a coherent practice approach for the benefit of children and their families. Other therapists are urged to follow suit by seeking therapist-academic partnerships to support documentation of practice. Only then will occupational therapists practicing in New Zealand develop their own, culturally specific body of evidence.

**Key points**

1. Story is a powerful cultural medium that therapists can harness for therapeutic ends.
2. Assisting children to tell their stories using sandtray therapy, peer group therapy and creation of an illustrated book provides them and the therapist with understandings drawn from the children’s perspective, which can then be shared with family and peers.
3. Telling and retelling their story helps children make sense of and integrate their experiences and feelings.

**References**


The children treated at Ladyfield are of primary school age. Two-thirds of them are of average intelligence and one-third belong to the educationally sub-normal group. These children suffer from a variety of emotional and psychiatric disorders, psychoses, neurotic disorders, organic brain damage or disease, reactive behaviour disturbances, epilepsy, psychosomatic and personality disorders. Of the children who come to Ladyfield, only a relatively small proportion, not more than one-third, are delinquent or likely to be delinquent. There are no exact figures for the relationship of delinquency to psychiatric disorder in primary school children, but from statistics of adult person populations and those of approved schools, which show remarkable agreement, it is reasonable to assume that about 25% of delinquent children of primary school age have obvious psychiatric disturbance.

These are children in whom delinquency has been evident when they were very young, from six to nine years of age, obviously too young to go to an approved school or when in older children the delinquency forms part of a severe behaviour disorder with obvious emotional disturbances. It is therefore a selected group and the treatment offered is an attempt to meet the need of these children. The children who have been diagnosed as behavioural disorders often come from deprived and disturbed backgrounds. They have deep seated mal-adaptive patterns of behaviour and present problems of stealing, truanting from school, running away from home, telling lies, larceny, house breaking, and excessive aggressiveness and destructiveness. Their relationships with people within their own family group, their neighbourhood, and their school are distrustful and actively hostile. They appear to have little capacity for learning from past experiences and for modifying their behaviour to avoid foreseeable pitfalls. They often come to us with a description of having little or no capacity for affection and a lack of trust in people, particularly adults, and they are not influenced in their behaviour by the possibility of pleasing them.

The 56 residents in The Children’s Unit, together with about 10 day pupils are divided between three houses, near to each other, with extensive grounds. The hospital staff consists of doctors, nurses, psychologists, psychiatric social workers and two occupational therapists. The school is staffed by teachers supplied by the local education authority. The life of the children is very like that of any residential school. They go home for holidays and wherever possible for weekends. A constant interaction between the family and the unit is maintained by the social workers and doctors. The nurses are responsible for the day to day care of the children, and a great deal of re-education in terms of upbringing. The individual therapy is shared by the doctors, psychologists and occupational therapists, and the occupational therapists are entirely responsible for the group therapy. It is this aspect of the treatment which I wish to describe.

GROUP THERAPY

Group therapy in Ladyfield is based on the saying, “Two’s company and three’s a crowd”. The children are perhaps the most disturbed in Scotland and to meet their needs the group is kept...
small. It is in part a very natural setting and the closest the child gets to the family situation within the residential unit. The main objectives in group therapy are:

1. To give the child an opportunity to form a close and meaningful relationship with another child and an adult.
2. To regain the lost confidence in himself and his abilities, and
3. To learn new patterns of behaviour which gain approval rather than disapproval.

Within the limits of personal safety the child is given a free range and choice of activity and thus the therapist is able to assess the child and his capabilities in a non-structured situation. There are three main facets of the child’s behaviour which the therapist looks for in the group:

1. A general assessment of the child’s abilities, difficulties and potentialities.
2. The relationship with the other child.
3. The relationship with the Therapist.

In her observation of the child, the therapist is looking for normal spontaneous responses, any oddities of behaviour, voluntary and/or involuntary movements, or whether his speech is meaningful or defective in any way. The child’s emotional responses if he is inhibited or aggressive, happy or unhappy, and his reactions to mild frustration and discipline. Also, if there are any signs of regressive behaviour, e.g. baby-talk and noises, and wanting to be cuddled.

In assessing the relationship with the other child, the therapist looks for signs of rivalry, aggression by physical or verbal attack, and whether he can control his aggression towards the other child. If they play together, or ignore each other, their attitude to sharing tools or toys, taking turns, and sharing the therapist’s time and attention. In the child’s relationship with the therapist, she looks for a strong or weak rapport, any show of affection or aggression, negative or resistive behaviour, and any indication of ambivalence. If there is any evidence of testing out and the child’s way of ascertaining his complete acceptance of the therapist, whether by aggression or withdrawn behaviour.

Going on from describing the child’s behaviour and relationships within the group, the therapist then describes his reaction to his environment. The activities freely chosen, the degree of interest shown, level of performance, concentration and sustained effort the child has for constructive activity, any destructive tendencies, insight into and understanding the project and the degree of manual dexterity.

On occasions particularly in the playroom the child, through the use of puppets, dressing up clothes, games of houses and play in the sand tray, will express fantasy material about his hidden fears and anxieties. More often than not this appears in the individual therapy sessions, but when a child through lack of therapists, is not receiving individual therapy, he may produce this material in his group therapy and the therapist must be prepared to cope with it. What the therapist does learn from the child in the group is his feelings and attitudes about Ladyfield, his home and his interests. In relation to his anti-social behaviour an appreciation can be gained of the child’s attitude to authority, tools and property, and the wishes of the therapist and the other child. This will not necessarily come in the first two or three sessions and it may take months before a child’s trust and confidence is gained, but I have found that fewer questions and pressures, within a secure and friendly setting, result in a quicker, more spontaneous and positive response. It breaks through the many negative, resistive and hostile feelings the child has to adults and any form of authority. The valuable aspect of it is that the change comes from the child himself, and all that the therapist is doing, is giving the child the milieu in which this change can take place. Foukes and Anthony, in their description of ‘treatment’ groups state, ‘That the occupation may be of secondary importance therapeutically, whereas active participation in the group setting may be the essential therapeutic agency.’ This is very much the line of treatment which is followed in group therapy in Ladyfield.

The following two examples of group therapy are about children who are being treated in Ladyfield at the moment. It will give you an idea of what has happened, what is taking place at the moment and what we hope to achieve for the future.

CASE STORY 1

Michael was referred to Ladyfield at eight years of age because of truancy from school, running away from home and such anti-social behaviour as fire-raising, stealing and house-breaking. His background is a disturbed one and during Michael’s lifetime the father has spent most of his time in prison. His mother is described as being inadequate and ineffectual, but at least under very difficult circumstances she has managed to keep some sort of home together, for herself and her three sons. Michael is a child of good average intelligence and attainments and in reading he is well above the mean for his age.

Michael was placed in a group with John, a boy of his own age and similar emotional disturbance but who had a lower I.Q. and level of performance. He presented a picture of a very independent little boy who was very quick and skilful at everything he did. He related to the therapist in a cheerful, friendly manner, but without any real effort to form a close relationship. He made an attempt to play with John but John refused, and without showing any sign of emotion, cheerfully turned to the therapist for a game of darts. On one occasion he went over to the puppet theatre where John was playing and he played at one end while John played at the other, each presenting completely different stories. In Michael’s play there was very little verbal communication between the puppets as they spent most of their time fighting, and being hauled off by the policeman to jail. By popular request the boys had a cooking session. They shared the same ingredients and utensils and behaved in a very friendly way towards each other, chatting about their home lives and all the things they would like to cook. In woodwork however they again pursued their own independent course. They were determined to make...
different things and have as little as possible to do with each other. Michael's level of performance and concentration throughout the term was good, he was bright and cheerful but his emotional contact remained superficial and uninvolved.

Michael then spent a period of three months at home and returned to Ladyfield during the summer holidays. He was a changed boy on his return he came along with a troubled and warned look on his face and didn't stay for more than five minutes at anyone activity. While at home, the family situation had changed quite markedly with father returning from jail. It appeared that his father now meant something to Michael but the intensity of his feelings was very difficult for him to express and cope with in the still rather insecure family situation. He flitted from the darts to the puppet theatre, then to the sand tray and back to the darts again. He carried on like this for a week or two before settling down to a definite pattern of behaviour. Then the first thing he did when he came in was to feed the hamsters; secondly water the plants, whether it was raining or not; and then he would settle down to a game of darts or scrabble. The other activities he did in the group were playing tennis, shopping and trips to the sea-side.

At this time, in the security of the group Michael built up a closer relationship with the therapist, he talked a great deal about his dad, he told fantastic stories about what he did with him and of all the material possessions he had at home. People were beginning to mean something to Michael, he was expressing his fantasy life, what he wished his father would do with him and all the possessions he would like to have at home.

During the next term Michael was placed with David, an older boy of similar background and intelligence. He expressed a wish to make things to take home to his mother and started on a fruit basket. He lacked confidence and was very immature and babyish in his approach and sought continual reassurance and praise from the other boys by trotting out every few minutes to show them what he was doing: David was also being constructive, building a pigeon hut and the two boys related well in this situation. In games they quarrelled, David being domineering and arrogant, sometimes refusing to participate, but Michael remained cheerful and would turn to the Therapist for a partner in his games. Michael was beginning to show signs of defiance but was still very much the mischievous little boy who accepted and did everything with a grin.

Since this term, Michael has pursued a constructive and creative course of activity. He has gained in self-confidence and assurance; no longer seeks the immediate praise gained by the other boys and has completed several long term projects to take home to his mother. Where he has needed, and still does need reassurance, is that everything he makes will become his own property? With improved concentration, sustained effort and motivation, Michael is a happier child gaining approval rather than disapproval for his efforts. His relationship with the other child in the group has improved in that he is more involved. There is a great deal more peaceful interaction in their constructive activities, although in games they still fight and quarrel, but within normal limits. His relationship with the Therapist remains secure, with the beginnings of some warmth and affection. He is continually seeking approval for his efforts, not only within his therapy sessions, but also for any newly acquired skills in football and other activities he does with the children in the ward.

**Conclusion**

During the course of Michael's stay in Ladyfield, various anti-social acts occurred such as breaking into one of the doctor's houses. Michael will not discuss these things with the Therapist - he is anxious to maintain his image as a good and helpful boy. The final step in his therapy will be for him to be able to discuss these problems, to receive reassurances that the Therapist still likes him, although she disapproves of some of his anti-social activities.

**CASE STORY 2**

The next case I should like to describe to you is Jimmy, the second child in a family of seven, and now aged 10 years. The eldest brother has previously been treated at Ladyfield and Ian, the third child, has just recently been admitted. The family is a very disturbed one, their father left home about a year ago and mother is now managing with help from her eldest boy and from the Children's Department. Jimmy's problem is one of truanting from school, persistent running away from home and spending nights out in the open, which he described as great fun and obviously seemed to him as being adventurous. He is a boy of high average intelligence. His performance I.Q. being 23 points higher than his verbal I.Q. which probably can be explained by his poor cultural background, lack of verbal stimulation and of schooling through truanting.

Jimmy was placed in a group with George, a boy of average intelligence who had already spent about a year in Ladyfield and was due to leave at the end of the term. He refused to come at first and went and hid in the boys bathroom, but once the Therapist assured him that there wasn't anything to be afraid of, he came along. It was apparent that Jimmy lacked confidence in himself, was unable to trust adults and at that time was also unable at first to communicate, either to the other child or the Therapist. In fact he didn't utter a word during his first session. He gradually began to speak, first to the other child and then to the Therapist through the other child, only being able to speak directly to the Therapist after four to five weeks.

His play also closely followed the pattern that he had shown in his verbal communication, in that he chose at first to play alone, particularly with unstructured material, like toy Cowboys and Indians, gradually involving George and at a later stage the Therapist. However, it was interesting that although solitary at first, he was able to show aggressive feelings in his play and allow the more friendly child to display aggression which until then he had been unable to express. Jimmy showed a great deal of imagination and good concentration in this type of play and obviously had a need to get rid of his aggressive feelings. As the relationship between the boys improved, Jimmy was able to speak of his family, as George was ceaseless in his chatter about his own,
and was constantly showing his affection to people he cared for.

The next term Jimmy was placed in a group with Ian his younger brother. At first Jimmy felt protective towards Ian making excuses for his difficulties saying he was ill and couldn't concentrate. At this time it appeared that Jimmy had a tremendous need to care for his brother. However, this only lasted while Ian was inferior to him in his play activities and as soon as Ian became a threat, he became aggressive towards him, beating him up and thumping him at any opportunity. The Therapist felt this sibling rivalry to approximate much more to his real feelings for Ian and his protective attitude was partly a reaction formation and partly a need to have someone inferior to himself.

The Therapist allowed the boys to use her as they needed her and in fact she was almost ignored at first. Slowly they included her in some activities but only in the first instance as a neutral referee. It was only at the end of this term that she was accepted into their play this coming about by way of a challenge when one day Jimmy looked rather smug and said, “Can you play darts Miss?”

The Therapist replied “Yes” and promptly hit the bull’s eye, much to their consternation and her utter amazement. She was then alright and accepted as one of them. From there they proceeded to more constructive and structured play, but both needed a lot of encouragement to overcome their lack of confidence, which was manifestly shown in negative and evasive behaviour. The Therapist had to be firm in insisting on their doing something more constructive, as this evasive behaviour was becoming an ingrained pattern of behaviour, and their lack of confidence was preventing them from progressing further. On being faced with this situation they accepted it, almost with relief, and went ahead, being very proud of the end product, each admiring the other’s efforts. Having now reached this stage, they have been able to express their wish to continue this relationship with the Therapist and their warm feeling towards her.

In group sessions important scraps of information are often gleaned. One boy, whose mother was separated from her husband and was unable to control the boy, had been ejected in quick succession from no less than seven children’s homes and other institutions before coming to Ladyfield. Just before one holiday he demanded to be taken for a walk in his occupational therapy session to, collect conkers otherwise he stated, “You don’t want me to go to Borstal do you?” He explained that if he had conkers he would be able to keep his friend and his brother amused, instead of going off on wild expeditions. He came back from his weekend and triumphantly told the therapist that “he had lit no fires, he hadn’t stole anything, and he didn’t hit his mother”. This chance remark conveyed his real feelings, which he had never been able to verbalise before, and the alternatives he offered, his good behaviour, or Borstal, were strikingly true; thus, the child saw clearly that the wrong path was a distinct possibility and he was asking for help from the Therapist to save him from his fate.

**INDIVIDUAL THERAPY**

Next, I would like to go on and tell you about individual therapy. All children who come to a residential unit, often leaving home for the first time, are anxious and apprehensive about their new life and about their future. They need someone in whom they can confide and who can make sense of their changing world for them. The Therapist soon forms a warm relationship with the child, and, if she is prepared to listen, she will learn about the new environment into which the child has been projected, from his point of view. She also has a great deal of information from the doctor, teachers, nurses and the other children about the child. This helps to give a clear picture of the child’s problems and his mental defences, etc. The Therapist also learns about the child’s fantasy world, and later about his home environment.

Individual therapy involves helping the child to gain a better understanding of reality and, through the very close relationship formed with him to make a better adjustment to it. This is done partly by direct experience of the child’s and the Therapist’s, emotional reactions and partly by explanation and interpretation by the Therapist. These processes are illustrated in the following case history of a boy who was seen for individual therapy for three years.

**Case History**

John was presented to us in rather a spectacular manner having hit the daily newspaper headlines with, “A ten-year-old Scots boy who can’t stop running away has covered more than 2,000 miles in his wanderings”. Here are some extracts from his individual therapy sessions. John appears to be an anxious boy, out to gain approval, at times showing hysterical and melodramatic traits. He does, however, show consideration towards the Therapist and is also gentle towards animals. For the first two weeks John played with soldiers in the sand tray. He was hesitant about this and said to me “You don’t think it’s silly for a boy of 10 years 5 months to be playing with soldiers, do you?” The Therapist told him boys and men of all ages played at soldiers, so he need not worry about it. From this form of play, the Therapist observed that John could be ruthless and destructive. When one of his men was hit he would drop all other forms of campaign and was not satisfied until he had retaliated, he would become quiet, tense and conceal any form of emotion. If the Therapist won he would ignore her victory and would immediately start on another game in order to ‘prove’ himself. When he won he was not satisfied unless he won victoriously, with a margin of at least five soldiers.

It appears that John needs and wants adult figures whom he can respect and give him the security which he obviously lacks. The Therapist feels she has made a start in forming a relationship with him. He is very anxious to please but before going much further he has a great deal of testing out and aggression to express.

This he did in various ways during the next few months. At times he was restless and anxious, and said he wanted to run away, but would not do so as he did not want to let down the Therapist and the doctor who had helped him. He wanted to take up acting as a career and wrote to the Italia Conti Dramatic School in London. To our surprise he was given an audition and his Therapist took him down to London for his interview. On the way he gave her many tips about evading paying fares on the
buses and tubes. To our even greater surprise he was offered a place as they thought he had real talent, but this was a bit too much for the Edinburgh Education Authority and eventually he went to a Senior Secondary School of Maladjusted Children, where he has done well.

A final note on his Therapy, during which he talked more and more freely about his problems, reads "I feel John has not only coped with his problems at Ladyfield, but also those at home to the best of his ability. His relationship with his Therapist remains warm and secure and he has reached a level of maturity greater than anything I would have expected from a child in Ladyfield". Since he left Ladyfield, John has visited his Therapist and his other friends in Dumfries each holiday, and has discussed his problems with us. He has continued to develop in a way which is much more hopeful for the future than at one time seemed possible.

Conclusion
In the treatment of children in whom anti-social behaviour appears as part of the picture of severe emotional disturbance, the first aim is to gain the child's confidence. With this, his affection is readily given. Then either play situations, in constructive activities or in direct discussions, the child's attitudes can be explained. The close relationship established with the child makes it possible to help him come to terms with reality, and to modify his behaviour to conform more closely to the demands of society. The skills of the Occupational Therapist provide a very wide field of activities for the child, and are very suitable for work with children, but I would not myself undertake therapy of the mind I have described without some guidance from an experienced child psychiatrist. Therapy with disturbed children demands a team of experienced people working closely together.

Acknowledgements:
I wish to express my thanks to Dr W. B. Rogers Consultant Child Psychiatrist, and Dr Joan Currah, Senior Registrar, for their advice and encouragement in the preparation of this paper.

BIBLIOGRAPHY
Shoba Nayar, PhD

A thesis submitted in fulfilment of the requirements for the degree of Doctor of Philosophy at the AUT University, Department of Occupational Science and Therapy, 2009.

Abstract

Indian immigrant women are a growing minority group within the multicultural spaces of New Zealand society. Despite Indian immigrants being the second largest, and one of the oldest, Asian immigrant groups to this country, their experiences of settling in a new and unfamiliar environment have been largely overlooked. This grounded theory study using dimensional analysis was aimed at answering the question: ‘How do Indian immigrant women engage in occupations when settling in a new environment?’

In-depth interviews and observations of participants performing daily occupations were conducted with 25 Indian immigrant women living in one of three cities/towns located in the North Island of New Zealand. Theoretical sampling with constant comparative analysis was used to guide both ongoing data collection and data analysis. Categories were examined for their relationships and dimensions to arrive at a substantive grounded theory which has been named ‘Navigating Cultural Spaces’.

Performing occupations that reflected either the Indian or New Zealand cultures, or a combination of the two, were core elements in how Indian immigrant women settled in New Zealand. These ways of doing everyday tasks have been conceptualised as Working with Indian Ways, Working with New Zealand Ways and Working with the Best of Both Worlds. Working from each of these perspectives, the women sought to Create a Place in which they could ‘be Indian’ in a ‘New Zealand’ context.

In order to achieve the purpose of Creating a Place, Indian immigrant women constantly shifted between the three ways of working; thus, performing occupations that allowed them to reveal as much of their Indian culture as they felt comfortable with at any given time and situation. Their actions were influenced by the people, objects and social spaces that constituted the environment in which they engaged in occupations.

The significance of this study is that it reveals how the everyday occupations of Indian immigrant women are constantly modified through their interaction and interpretations of the environment, thus allowing them to move between and within the multicultural spaces of New Zealand society. This gives rise to Navigating Cultural Spaces which frames settlement as an ongoing and dynamic process and challenges the applicability of current models of acculturation in a New Zealand context. It is recommended that future research examines the migration process from an occupational perspective in order to assist with the development of migration policy and support services that best facilitate Indian immigrant women Creating a Place in New Zealand.
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