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### **Guest reviewers**

The list of guest reviewers for the year 2003 will be published in the March 2004 issue.

# Editorial

“Kia ora and Happy New Year to you all”, if it is not too late. 2003 is the “Year of Goat” according to the Chinese lunar calendar. The ancient character of the word “goat” in Chinese shares the same root with the word “peace and prosperity”. One can only hope this will be the case in the midst of imminent war and terrorist attack/ threat in different parts of the world.

Among the many admirable qualities of the manuscripts gathered in this issue is Henare’s article (2003) on pain and self-identity. Part of her work was presented in the Frances Rutherford Lecture at the New Zealand Association of Occupational Therapists 2002 Auckland Conference. It was followed by a book review (Christie, 2003) on the topic of pain management and occupational therapy. I am very pleased to publish two articles on therapeutic interventions in this issue, one on working with parents (Christie & Hedayati, 2003) and one addressing issues of fitness and lifestyle for people affected by psychotic disorders (Lloyd, Sullivan, Lucas, & King, 2003). Penman’s commentary (2003) is meant to facilitate some discussion amongst readers on how an article on therapeutic programme may have relevance to our prac-

tice and understanding of theories. I believe that is what a professional journal is all about. Lastly, who, for example, would dream of “spiritual occupation”? Or who would want to explore the relationship between occupational therapy and adventure therapy? It should be enough. I think Levack’s article (2003) will solicit few letters to editor in the next issue to continue the debate. If it does not, it is the fault of my expectation and not the guru.

In the next September issue, there will be special items to explore what are the challenges and opportunities for occupational therapy in relation to the emerging primary health organisations (PHOs) in New Zealand. Kinney’s viewpoint article (2003) serves a useful introduction to this topic. Like other initiatives, you are invited to help contribute to this exciting issue either as an author or reviewer; I look forward to hearing from you. We definitely need colleagues who have expertise knowledge on the subject of primary healthcare to help.

**Editor**

**Samson Tse**

14 February 2003

## Acknowledgement

I would like to gratefully acknowledge the support from the following colleagues who provided excellent review of manuscripts for the year 2002 issues: Dr Maria Bellringer, Robert Bull, Marie Chester, Ann Christie, Tim Dunn, Trisha Egan, Sandy Elkin, Beth Gordon, Wendy Jones, Julie Kenning, Lyn Leadley, Chris Lloyd, Tricia McGuinness, Shirley Milligan, Dr Elaine Papps, Merrolee Penman, Dr Neil Pickering, Dr Linda Robertson, Rowena Scaletti, Gretchen Simms, Jake Tahitahi, Dr Hector Tsang, Dr Katrina Varian and Nancy Wright.

I express my sincere thanks to all of you for your many useful suggestions, enthusiasm and assistance in supporting this Journal.

# "It just isn't me anymore" moving forward to a new identity

Diane Henare

Early version of this work was presented as the Frances Rutherford Lecture in the New Zealand Association of Occupational Therapists, 2002 Auckland Conference. After the Lecture, Ms Henare received a standing ovation from her audience.

## Abstract

When illness or disability enters a person's life their sense of self or identity can be threatened, and is often experienced as changed. For many, this experience is difficult to deal with as they first deal with the loss and then begin the journey to rediscover or redefine themselves. Participation in meaningful occupation is an important part of expressing self. Listening to people's stories also helps us to know the person. Occupational therapists have a significant role to play in working with people to assist in rebuilding identity through the tools of engagement in meaningful occupation. They are also involved in hearing their narratives. The narrative and art works of people who experience chronic pain have been incorporated into this article to allow deeper understanding of the experience of loss of and regaining of identity.

## Keywords

Occupational therapy, self, rediscovery, redefining, rehabilitation

Henare, D. (2003). Frances Rutherford Lecture: "It just isn't me anymore" Moving forward to new identity. *New Zealand Journal of Occupational Therapy*, 50(1), 4-10.

I have put extraordinary effort into living an ordinary life. It was up to me to create the life I have and only I ever had the power to do so. Those involved in my rehabilitation have only ever been involved in the role of guidance, never the creation – "I am my own Masterpiece."  
(Telfer, 2002, p. 15)

This young woman momentarily lost who she was, following a brain injury, but regained herself through her rehabilitation. This article takes as its theme the loss of identity and the path to regaining it when illness or disability disrupts lives.

The narrative of a woman (Josephine) who has been prepared to share her story of identity loss and recovery will be offered as personal experience. I wish to thank her for her generosity and hope that hearing parts of her story may help us all to reflect on how we are with the people we work with and how we may help or hinder their need to re-establish their identity following illness or disability. The art and narratives of other pain programme participants, Karen, Rita, Marge and Brian will also provide insights.

## Identity

What is identity? According to *Collins Dictionary* (1987) identity is, "the state of having unique identifying characteristics. The individual characteristics by which a person or thing is recognised" (p. 494). The thesaurus gives words like distinc-

tiveness, individuality, self, selfhood, singularity, uniqueness, and personality as synonyms.

Christiansen (1999) describes identity as being a composite definition of the self: The interpersonal aspects, roles and relationships, possible potential, the who we might become. Christiansen also acknowledges the influence of and the inter-relationship with others in our interpretations of what we do and who we are. He indicates that identities are socially interconnected. If my identity changes, that has impact on those whose life I am involved with. If I become disabled someone else may have to take up a new role and therefore also take up a new identity as my caregiver.

Hocking (1999) describes identity as complex and also refers to descriptors such as self-concept, self-image, sense of self. She describes it as the answer to the question "who are you?" According to Hocking people compose themselves through their lived experiences which include their social interactions, physical environment, historical and cultural meanings. She states that people strive to maintain coherence

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in their understanding of who they are, what they might do and how they might do it.

McCracken (2002) described self as the union of elements: Body, emotions, thoughts and sensations that constitute the individuality and identity of the person. He outlined three dimensions of self.

1. The conceptualised self – the popular understanding where a person possesses a list of their personal characteristics within their life histories. The person expects and is expected to act consistently with what they say about themselves. Threats to these personal characteristics are a threat to identity.
2. The second sense of self is ongoing self-awareness.
3. The third sense of self is the self as “observer”. The self as “observer” is separate from thoughts and feelings, a state of mindfulness, a place to reflect and accept the need for change and acceptance of change in self.

Christiansen (1999) presented a view that occupation is the principal means through which people develop and express their personal identity. He comments that people’s competence in performing tasks and occupations makes a contribution to shaping their identity, and when a person has an acceptable identity this contributes to coherence and well being. Engagement in meaningful doing is a vital key to identity and the point at which the occupational therapist is involved. Human agency as described by Sen (1999) is that of expressing oneself through acting on the world around us. When we engage in occupations we are acting on the world around us, we are taking an opportunity to express self, to create an identity.

When something unexpected strikes and involvement with occupation is challenged the change may be seen as a negative experience. It is so noticed and conscious that people feel that they are no longer who they want to be. Kerby (1991) expresses the view that for most of our lives our concern with identity is marginal. The question is more likely to arise in crisis situations and at turning points in our routine behaviour. For example on admission to hospital or the beginning of retirement people may be placed in a position of retrospection, and notice that the changes have cumulatively been significant. These are times when identity can be seriously threatened. Therefore performance limitations as a result of illness or disability have implications for identity and as occupational therapists we need to be aware of this.

## Loss of identity

The onset of chronic pain can be one such situation and will be the main clinical area that I intend to use to illustrate the issues of loss of identity.

At some time in our lives most of us will experience pain severe enough to require us to take time away from our primary occupation. It is a universal experience but it is also a personal experience. No one can tell me whether my pain is better or worse than anyone else’s. It is my pain and I can be the only judge of its severity. For most of us that pain will be short lived, and as healing takes place; the body restores itself to its normal level of function and we have our sense of self intact.

However epidemiological studies show that for a percentage of the population – about 10-15%, pain stays for more than three months and becomes chronic pain (MacFarlane, 1999). Some people seem to cope with the ongoing nature of the pain and keep engaged in their occupations. They are known as the “adaptive copers”, but for a group of people the onset of chronic or persistent pain begins a downward spiral of losses.

The initial response to managing chronic pain is to rest, to avoid doing those things that stir up the pain and to take some medication, painkillers of some sort. The pain eases, or subsides for a while. If the problem is acute pain – a few days or maybe weeks of this and the pain is gone, and the person gets back into their normal life. However for those with a chronic or persistent pain problem – and as yet they are not aware this is a chronic pain problem – the initial reduction in pain, followed by pain on exertion or increased activity reinforces this type of management of rest and avoidance. If the pain problem goes on for weeks, months or years the person will begin to experience losses in their lives – loss of recreation, sports, loss of job, loss of friends, social activities, loss of, or strain on, family relationships. They may fear moving and being active. They experience frustration, irritability, fatigue, anger, depression, which leads on to loss of self esteem, loss of self, and at times even total loss of self through suicide. Identity is threatened or lost.

Josephine is a woman with persistent pain. She sustained a lifting injury at work many years ago. She had experienced other episodes of pain since then but the pain usually eased and mostly she kept going at work. This time she hurt her back lifting a heavy item into the boot of her car and the pain went on. She said:

“The severe pain that I had was like nothing I could describe ... I couldn’t see where I was heading. There was no future. I couldn’t plan ahead properly, and so there were those things that I either had to put off or rethink. I wasn’t allowed to drive, I had to watch my garden get overgrown, I missed going to the pictures for about a year because I couldn’t sit for long enough.”

Figure 1 is a picture created by Karen to portray the meaning of her pain. She explained, “The square is the way my pain holds me in so the pain is everywhere and it felt like ... there is nothing in my life but pain”. It is a desperate place to be.

For Josephine and Karen, their pain experience was taking over their lives, taking over the selves that they had previously been. For



Figure 1. Picture by Karen

them the pain was persisting after healing had taken place. It was no longer serving the useful purpose of warning of damage, but had taken control, curtailing their activities and shrinking the boundaries of their daily experiences, disturbing their sense of self. Susan Baptiste (1988) in her Muriel Driver lecture described the effects of chronic pain as the agony of accepting the loss of the old skills, the present sense of failure and the fear of future helplessness.

Painkillers, rest and avoidance of activity were not working for Josephine and Karen. Their lives were getting more and more confined as reduced activity restricted their interactions with others. Many people in this predicament begin a search for a cure or for someone who can treat them and make a difference. So they begin the rounds of health professionals and alternative healers, sometimes finding something that works for a while but mostly being disappointed. At times the person is told that "it's all in your head", or they are treated as someone who is not trying hard enough, a "bludger". This can be the beginning of an identity as a loser, a person without hope.

Chronic pain is a condition for which there is no cure. Health professionals and alternative practitioner's behaviours can strongly affect the disability and duration of the pain once it is established. Some patients have reported that their doctor has told them they will end up in a wheelchair. Such comments create fear, as people contemplate the possibility of long-term damage or the fulfilment of the doctor's view that they could end up in a wheelchair. Lack of acknowledgement of the pain's reality by others can leave people feeling that may be it is all in their heads. They begin to fear that their future identity is as a disabled person.

Chronic pain is an inner experience and others cannot share in the suffering.

This was highlighted for me during my interview with Josephine. An important aspect of Josephine's identity was as a truthful person so it was important to her to be believed and to be helped. She had two experiences with health professionals that left her feeling discounted and less of a person. The first was her GP whom she thought she had a good relationship with. He would not refer her on for a specialist's opinion. He said she just had "nurses back", that it was stress. She felt unbelievably. She remembers walking out of his office feeling absolutely empty. She was a nurse. She said:

"There was an expectation that I knew things more than I did and I believe when you are actually in an injury state yourself you know you are not rational in the same way. You are not thinking of everything in medical terms. There's times I guess when you just want to be accepted as a person that needs help, rather than anything else. At this stage I couldn't sit, I couldn't walk any distance. I had dependent children, so yes, the first few weeks were extremely traumatic. I felt as if I wasn't believed."

It was important to Josephine's identity to be a person who was believed.

The second interaction was with an occupational therapist 18 months into her chronic pain, when Josephine finally received some input from other health services. Josephine described:

"The occupational therapist started the conversation by saying that she had had back pain in the past herself but it had settled. I felt like saying but – this is different, but I couldn't articulate it because I didn't understand why it was so different. I felt unbelievably and discounted."

It is likely that the occupational therapist would have been unaware of what she had said and the impact of it. She was probably intending her interaction to be empathetic. While the work done by the occupational therapist regarding her workstation was helpful, Josephine continued to feel defensive about her problem and consequently a good therapeutic relationship did not occur. It is probable that the occupational therapist never knew why.

Rather than face their chronic illness or disability, some people will retreat into the safety of home and wait until they recover (Charmaz, 1991). They may expect to wake up one day and they will be their old selves again. For people with chronic pain we see this when rest and avoidance is used as the coping model of choice. Control is important and one way to control symptoms is to rest and avoid doing. When the self is taken over by pain identity is experienced as lost.

For many people the identity they had in the past before becoming disabled or unwell is the identity they cling to. They often can no longer confirm that self with their actions as they lose skills and abilities. For elderly people in care, the prior self is often unknown to the caregivers and is often unacknowledged. Gooder's (2002) work *Becoming human again: Older adult's experience of rehabilitation in Hospital* also identified this issue of loss of identity and its place in recovery for older adults in rehabilitation wards.

## The experience of loss of identity

For the person who develops a pain problem from whatever source there is an initial expectation that it will be short term. Then they expect a return of function, a return to activities or what they may think of as their normal self. They expect to get on with their lives. But as we know for some people, pain, or other chronic illnesses or disability can come and stay. How must it feel to be getting on with life to have a job, roles, and tasks, activities that are engaged in without much thought? They are your life, they reflect you. Then one day you become aware either suddenly or gradually depending on the illness or disability you encounter, these occupations can no longer be taken for granted. They are no longer a part of your life in the way that you knew them and you begin to feel the loss of self as you lose engagement in meaningful occupations.

Josephine is a mother and a nurse. She had been a nurse for many years. I saw her as a nurse, Josephine saw herself as independent, and an achiever – two words she uses to describe who she was as a person. With the advent of her pain problem she found it very difficult to do some of those things which defined her as mother and worker – household tasks, driving her family to activities, gardening. She felt she was losing independence (losing self). Six weeks after the onset of this latest experience of pain she told the physiotherapist that she was going back to work. She needed to, for her sense of self. She managed two

hours a day at her job, which she said, “seemed to me to be absolutely crazy.” This was not her. Many of the tasks in her job involved sitting and she could not do that for the length of time required in her job. She experienced a great sense of loss as she thought back on her working life. She had always thought that one day she might go back to working as a theatre nurse a role she had held for 20 years. Now she realised that this was a dream that would not be a reality. She felt a great sense of restriction and loss of future options. Her colleagues further compounded the loss of self. She said:

“One person used to walk past my desk everyday and say, ‘How’s your back?’ She couldn’t ask me what the weather was like or any other topic of conversation ... I felt that I was being isolated out and I wasn’t included in things because it was seen that I couldn’t do it. I wasn’t consulted before the decision was made. I felt at times that I was seen as an ACC bludger. That reared its head quite a lot of times and gave me a sense of guilt ... I struggled with that myself. I was scared of becoming dependent.”

In Figure 2, Rita shows graphically the way she sees her damaged body. It is as if it is no longer hers, it is cut off. Rita explained:

“What happened to my life was just like a thunderbolt. I wake up with it and go to sleep with it and it is better or worse but always there. It is a pretty bleak, black outlook for me. It burst my bubble ruined my life. It hasn’t physically stopped me doing anything, may be just a couple of things but it has slowed me down so much ... But it’s just so black so much of the time because it’s just not me anymore.

A slowed down person was not Karen. She had always been a busy person, doing things at a fast pace. A dependent person was not Josephine. She had always been a productive person and a competent mother.”

The experience of loss of self is not limited to the experience of chronic pain. Gooder’s (2002) research on older adult’s experience of rehabilitation in hospital also demonstrates this concern. She noted a change to these older adults’ sense of self when they experienced a reduction in their health status, whether it was measured in levels of pathological change or in their ability to be involved in tasks and participate in their life roles. One of the participants, Maurice expressed his changed sense of self, “He described the situation as strange. Strange

because he had been and was no longer the strongest, best, fastest. Strange that he was himself, but not himself” (Gooder, 2000, p. 45).

Of the situations, which challenge identity in the older person, increased frailty has a big impact on the potential to engage in valued activities. The altered body which does not function as it once did, is experienced as no longer being dependable. Opportunities to engage in social interactions become more limited when people are unable to get out and about. If speech or language is lost people are unable to tell others of their identity through their stories (Gooder, 2002). After rehabilitation the identity of each was changed as none of them went home at the level of function they had before their illness or trauma. One woman said, “the struggle to come to terms with the new restrictions (of the body) has been the most difficult to accept because I am different now” (p. 58).

I would like to use the example of my father who died last year aged 93. I have reflected on his life and his determination to retain his identity as long as he could. He was a practical man a person who liked to do things with his hands. As a young man he was an electrician but he was also the practical problem solver, the inventor. He was always trying to find a way around things by making something useful. He did all the usual things: working, building a home, providing for his family. One particular feature was his interest in food, generally the consumption of it. He retired from work, became a traveller, gardener, played bowls and continued to problem solve, invent and make things. He moved to a retirement village and these identifying characteristics remained although they became slowly less and less part of his daily life. As he got older he was less able to do physically challenging things but he developed cooking skills and enjoyed nothing more than to cook a three-course dinner for family or friends. He also enjoyed the eating. By the age of 92 following three strokes he came to the time when that was about all that was left in his day. After each stroke he rehabilitated himself largely to continue cooking. This was a critical part of his identity. Planning meals and preparing them were his primary occupations. Cooking provided an opportunity for social interaction when he could cook a meal and share it with a friend. He gradually modified what he was able to do by buying pre-cooked or pre-prepared vegetables so that he still had control over his meals. Then he had a fall and a subdural haematoma, which affected his mobility. He was no longer able to shop, no longer able to cook, nothing to think about in terms of planning his shopping list, or planning what he would cook for his next meal. This was the last remaining activity that he controlled and through which he could express his individuality. He had been able to cope with all the other losses and had successfully redefined himself again and again but now had nothing to do to reinforce who he was. He was no longer a competent problem solver, as he could not find a way around this last blow. He became what he had always dreaded, a person living in an old people’s home where he had little control over anything. When that occupation was no longer available to him he lost himself.



Figure 2. Picture by Rita

## Loss of self leading to ill health

The focus to this point has been on the impact on identity of illness and disability. The reverse situation is also of concern where loss of self and identity can lead to loss of health. When people feel that they have no identity or the characteristics of that identity are not valued by society life can become meaningless. The situation of loss of culture is one such issue and can link to loss of identity and subsequent ill health (Durie, 2001).

For Māori (New Zealand indigenous people) to acquire a secure and, meaningful identity, to enjoy good health and sense of well being then they must be able to live comfortably as Māori and as citizens of the world. To live comfortably they must have access to whanau (family), marae (meeting place for the people), turangawaewae (home), fisheries, language and culture. It is not just about personal expression, but also the opportunity for cultural expression within society's institutions. The recent engagement of Māori students in the school kapa haka competitions in September 2002 demonstrated the importance of kapa haka to their expression of identity. Kapa haka, which is cultural expression through music and dance, enhances self-esteem and identity. Politicians were arguing that these skills were not relevant as a qualification. There is enough evidence to show that negative identities accompanied by de-culturation have been shown to cause mental illness, alcohol misuse, suicide, aggression and criminal offending (Durie, 2001). Durie states that the establishment of positive cultural identities has been shown by indigenous peoples to be a key to improved mental and physical health. The kapa haka issue is one of establishing positive cultural identities for these young people and possibly therefore having a positive influence on their health and wellbeing.

Far-reaching negative consequences for Māori health and well-being have resulted from the erosion of identity in Māori society (Jungerson, 2002). These issues of loss of identity are not about loss through illness or disability but through loss of culture. Meaningful occupations that have cultural relevance help to enhance identity.

## Regaining or redefining self

The question for occupational therapists then may be "How can I help those people I work with to maintain, regain or redefine their identity?" Using the chronic pain model as an example it is helpful to look at the principles of pain management. About 30 years ago a rehabilitation psychologist, William Fordyce, came to the conclusion that acute treatments did not work for chronic pain and he developed the concept of dealing with the results of the problem. He set up the first pain management programmes, which acknowledged that the pain itself could not be treated, but the effects of it could. People could get control of their lives again and re-engage in those things they wanted to do by dealing with the effect of the pain in their lives (Fordyce, 1976).

The rehabilitation approach with chronic pain is to work with these people to confront the pain and their fears of increased pain, to understand their pain and to get back into

activity. The person with pain is encouraged to regain meaningful occupations or take on new ones, to learn to relax, pace and regulate their activity, to take control, to make gains instead of losses – gains in function, in doing. Through these gains the person regains self-esteem, regains or redefines self, gains self-actualisation.

The issue then of working with people with chronic pain is not to focus on their pain but on restoration of function and an acceptable sense of self. So the skilled physiotherapist can get the person's body functioning as strongly as possible and the psychologist can work with people's cognitions and beliefs about pain. The anaesthetist can provide medications and diagnosis and the occupational therapist has an obvious role in enabling and empowering the person to move towards achieving engagement in meaningful occupations. Each member of the team in their way with their professional skills is working towards helping the client to redefine self – a different self or a restored self.

In my job the first thing I do with the patients is to try to gain some knowledge about who this person is. I must begin however with a sense of "unknowing", of leaving behind previous knowledge about this person (often only medical knowledge). A diagnosis will not tell who this person is. A diagnosis does not define the person or their difficulties so I begin with gaining the narrative. As I listen to the narrative I gain some knowledge of how they see themselves in the world at this point in time. I may get a sense of the past self and I may get a sense of who they want to be in the future.

Josephine's narrative had elements of agency of wanting to retain her autonomy. She took control by arranging her own specialist appointment, by changing general practitioners to one whom she felt believed her. She negotiated an arrangement with her physiotherapist so that she was in charge of the times she did her exercise and that she could access the gymnasium whenever she felt she needed extra work.

Marge's picture (Figure 3) shows the characteristic activities she was involved in before her pain and since her pain. She said:

In the centre ... there's a picture of a woman looking out the window looking rather morose and sad which indicated the way I feel sometimes because of the pain, but (she is) also looking out and beyond and trying to get a good perspective on life.



Figure 3. Picture by Marge

Marge has tried valiantly to remain the self she has always been. Her narrative and her artwork have helped to allow us to “know” who she is. She has worked at maintaining relationships and has stayed active by adapting activities in order to stay involved. She has continued to be an agent in her own life. She used to be a nurse and loved her job, she liked walking, gardening, looking after her grandchildren, cooking, preserving fruit, boating. Now she gardens using pots so she can manage more easily, but still get the rewards of flowers and vegetables. She bakes still; she has ingredients and equipment on a higher level to enable her to reach them more comfortably. She reads to keep her mind busy, she does different activities now with her grandchildren and as they get older she finds her limitations less of a difficulty as they can do more for themselves. At the time she made the picture, she had not returned to work, but she has since gained a position in a community education role and feels more like the woman she used to know but has had to come to terms with a different self.

We want to demonstrate to others that we are competent (Christiansen, 1999). Successful completion of a task adds to our sense of competence, bolsters self-confidence, engenders a belief in self-efficacy. That is why it is so important that when we work with people we work on achievable outcomes that will engender a success experience for the person. If our identities are crafted by what we do and how we do it then it follows that any threat to our ability to engage in occupations and present ourselves as competent people becomes a threat to our identity. Difficulties with competence and performance limitations are part of the lives of most of the people we see otherwise we would not be seeing them. As the therapist we assist the person to recreate coherence, and continuity to replace that which is lost or disrupted, to find self (Christiansen, 1999).

The young woman I quoted at the beginning is a great example of agency and regaining self. She says, “I disappeared into a coma and was absent for ten days... It felt like the hospital and the injury were a dream but I always knew ‘I was me’” (Telfer, 2002, p. 15). Her family preferred to have her cared for nearer to home and took her home where she was with family and friends. She says:

“This was a period of constant frustration, boom or bust and trial and error. It was this process that helped me discover my new self and limitations... It was my family’s complete knowledge and acceptance of me that helped build the foundations from which I could regain my security and identity. The constancy and security of my family and friends around me reminded me of my past and whom I used to be. It also allowed me to develop, with their help and influence into whom I felt I was and wanted to be (p. 16).

Activity, occupation, and engagement seem to be key in this process of identity lost and found.

## Occupational therapists as partners in identity building

How can we as clinicians guide people to create a clear and positive sense of self in the future? As stated earlier one of the ways to get to know the person is through their narrative.

Polkinghorn (1991) says of narrative:

“It is used to interpret and give coherence to past episodes and to configure future activities that we expect to lead to desired outcomes ... that narrative is used to give form and meaning to our lives... It is the narratively structured unity of my life as a whole that provides me with a personal identity and displays the answer to ‘Who am I?’” (p. 143)

Occupational therapists while using the narrative to get to know and understand the person can help them move on with a positive plot. They help by enabling positive experiences through successful engagement in meaningful activity that helps to promote positive narrative.

One of our unique capabilities as occupational therapists is that we can provide opportunities for meaningful doing for our clients. This meaningful doing may enable experiences that can transform and create a belief in possibilities that were thought lost or were never imagined (Spencer, Davidson & White, 1997). The occupational therapy intervention is nothing spectacular or earth shattering but is about facilitating that movement forward by positive achievements and encouragement. It is often about achieving simple goals and simple tasks taking very small steps into the future and enabling that process of identity building. We do not need to do anything differently but rather to be aware of the importance and the impact of what we are doing, together with the patients and clients we work with, in assisting identity.

Looking at Brian’s picture (Figure 4) we see a man who sees a future self. He has a bridge crossing the gap to things he sees as better: sunshine, fishing, sitting under the trees relaxing. He sees himself engaging in activities, new skills taking him towards this goal.

Occupational therapists are partners in identity building encouraging people by using occupation to create optimism, choice, and control. As Wilcock (1998) argues the unique understanding that occupational therapists bring is that occupation includes all the things that people do and the relationship of this to who they are as human beings.

I will leave the last word with Josephine.

Josephine says of herself:

“I am a nurse; I (now) look after (me) the person. It’s a case of getting that balance. I’ve got my sense of achievement back ... While I lead a normal life and I socialise and do things, I do have to forever be making choices.”

She now works independently and has a small business. She says:

“I have enough work coming in. I probably work about 20 to 25 hours week. I’ve got projects I want to do. I work as I feel



Figure 4. Picture by Brian

like. I do have deadlines to meet and that’s fine. There’s always going to be a balancing act. I am no longer on ACC... I don’t feel as though I have to justify myself to other people who I am.”

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# Pain: A Textbook for Therapists

Jenny Strong, Anita M Unruh, Anthony Wright and G David Baxter. 2002. Edinburgh: Churchill Livingstone, Harcourt. 461pp. NZ\$149. Paperback.

Reviewer: Wendy Christie, Dip OT, Queen Elizabeth Hospital, Rotorua, New Zealand

*Pain: a Textbook for Therapists* has been designed primarily for occupational therapists and physiotherapists. It was developed for use in conjunction with the International Association for the Study of Pain (IASP) curriculum to support health professionals with their development of knowledge and skills in the assessment and management of pain. The expertise of seventeen contributors from around the world has been brought together through liaison and work across a number of countries, including New Zealand, to create this resource. It has been written to assist health professionals gain a better understanding towards people with pain and to encourage a more effective and evidenced approach their treatment and management.

Both theoretical and practice based applications are encompassed within. It is recommended to be an extremely valuable resource for curriculum education in occupational therapy schools and clinical practice settings involved in the treatment and management of people with pain.

Expertly written, the book is based on current research and contains a detailed reference list at the end of each chapter. It challenges readers to keep up to date in their knowledge and practice, as research is continually exploding with new discoveries and understandings about pain. Throughout, there is a pronounced emphasis on the need for evidenced based practice. References and information on steps to developing an evidenced based practice is provided.

The book is effectively constructed with each chapter being formatted in the same structure, containing an overview of the

topic, learning objectives, conclusion and ending with study questions and questions for revision. In general, the content of the book is easy to read, however some of the technical topics may be challenging for some readers. It is necessary to take into consideration that many of the chapters in this book are relevant to both occupational therapy and physiotherapy professions, but there are some chapters which are more specific to one profession. Case examples, illustrations, diagrams and reflective exercises are also incorporated to promote and stimulate understanding as well as allowing for different learning styles. The reflective exercises do encourage the reader to reflect on their own pain experiences, experiences of family or friends and clients.

The content of the book is divided into four sections.

The first section focuses on establishing an understanding of pain. The introduction discusses the roles, theoretical perspectives, legal and ethical standards for occupational therapists and physiotherapists in the management of pain. This is followed by topics on neuroanatomy, neurophysiology, psychological, environmental and behavioural dimensions of the pain experience. Lifespan and cultural influences are also discussed. The second section provides an overview of models and methods of assessing and measuring pain. It addresses the reliability and validity of specific measurement tools. The third section examines specific assessment and practical intervention approaches such as re-integration into work and lifestyle management. It also contains some chapters which are specifically orientated to physiotherapy. The fourth section discusses common pain problems including musculoskeletal, neuropathic, cancer, acute and chronic pain.

It is considered that the editors have achieved their objective of writing a comprehensive textbook on pain for therapists. This book provides an integrated approach for occupational therapists and physiotherapists in the assessment and management of people with pain conditions. It is an excellent reference book for ongoing professional development.

# A programme for parents of children with challenging behaviours: An occupational therapy approach

Ann Christie and Laura Hedayati

## Abstract

The Challenging Children and Parenting group, named for behaviours to be seen as challenges to overcome rather than unsolvable problems, is for parents of children who have mental health disorders. Over fifteen years the group has developed a manual, a referral brochure and systems evaluating content, knowledge gained, and discipline practices. A collaborative model of intervention encourages a democratic parenting style and self-advocacy through interactive group participation. The model includes child and adolescent development, learning, and behaviour approaches. The strength of this programme lies in its consistency of leadership, depth of evaluation and contribution from parents and co-facilitators.

## Key words

Parenting group, child mental health

Christie, A., & Hedayati, L. (2003). A programme for parents of children with challenging behaviours: An occupational therapy approach. *New Zealand Journal of Occupational Therapy*, 50(1), 11-16.

## Introduction

The Challenging Children and Parenting group (CCAP), named for behaviours to be seen as challenges to overcome rather than unsolvable problems, has been operating since 1987. CCAP has evolved over time and responded to the changing New Zealand health system, an increasing focus on financial and professional accountability, and client centred practice. Client centred practice contains a strong focus on client needs, meaning the family inclusive of parent and child. Evaluation of the group content, delivery and development of practical strategies to assist parenting practices is ongoing.

Parenting is a major occupational and social role for families. The lifetime skill of parenting (Christie, 1999; Cronin-Mosey, 1996) provides challenges that may be rewarding and empowering, or may place disproportionate strain on traditional parenting practices and the family system. Optimal child's social, emotional, and cognitive development is dependent on how parents both care for, and relate to, their children (Dinkmeyer, McKay, & Dinkmeyer, 1997; Hetherington & Parke, 1999; Pryor & Woodward, 1996). When a child or adolescent experiences a mental health disorder which includes a range of challenging behaviours, the need for skilled parenting becomes essential (Silva & Stanton, 1996). The challenging behaviours of these children may be perceived as temperamentally difficult, inflexible, inattentive, moody and explosive with poorly developed thinking skills. Children are often highly anxious with low self-esteem. The New Zealand multi-disciplinary longitudinal study in Dunedin presents an intergenerational perspective of parenting, providing information on the effects

of inherited parenting practices on children with emotional and behavioural disorders (Silva & Stanton, 1996; Williams, Anderson, McGee, & Silva, 1990). Participants in the CCAP group often discuss the parenting model that their parents provided. They acknowledge their often limited understanding of normal child development and the lack of training for this lifetime role.

It is not the intention of this article to make comparisons with similar parent-training programmes, but rather to demonstrate how the Kari Centre CCAP programme developed through evaluation from an existing researched programme to its present format. The CCAP group was established due to a perceived need for a parenting skills group for families attending the Child and Family Unit at Auckland Hospital. This outpatient service moved to the community in 1996 and was renamed Kari Centre 2002 where the programme continues to operate. The Systematic Training for Effective Parenting (STEP) programme (Dinkmeyer & MacKay, 1978; 1989) initially provided the content and structure required for our client

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base. Most programmes evaluated at that time seemed to meet the average parental need rather than the specific needs of parents of children with mental health disorders and accompanying challenging behaviours.

A collaborative model of intervention, three evaluating systems, a manual, referral process and brochure form the basis of the CCAP group process that progressed over time. The collaborative model encourages a democratic parenting style and self-advocacy, demonstrates democracy and respect (Dinkmeyer & McKay, 1989; Dinkmeyer, McKay, & Dinkmeyer 1997), collaboration between parent and professionals (Humphry & Case-Smith, 1996; Webster-Stratton & Herbert, 1994) and a workable plan of action.

### Theoretical components of CCAP

The American Academy of Child and Adolescent Psychiatry practice parameter guidelines (AACAP, 1997) for the assessment and treatment of children and adolescents with psychiatric disorders, were developed as a guide to clinicians. These guidelines emphasize that for treatment to be effective it must have a developmental perspective, be multimodal, address multiple aspects and continue over extensive periods of time. The policy of Kari Centre reflects this in their multidisciplinary, child, adolescent and family centred approach to clinical practice. CCAP employs a collaborative model of intervention (Webster-Stratton & Herbert, 1994) that includes child and adolescent development (Case-Smith & Shorridge, 1996; Hetherington & Parke, 1999; Sattler, 1998), learning and behaviour (Cronin, 1996; Greene, 1998) and open-systems problem management (Egan, 1994). These approaches guide the intervention and group process (Corey, 1982). Structures for group social interplay (Cronin-Mosey, 1996; Hagedorn, 1997) and a framework for problem solving (see Figure 1) that are essential components for dealing with the task of raising children with challenging behaviours are emphasised. These components include developing the interactive skills of parents, fostering improved relationships with children, child advocacy and parent empowerment (Barkley & Gordan, 1995; Egan, 1994) and the use of humour (Farling, 1997; Grusec & Goodnow, 1994).

There is a paucity of occupational therapy literature on parent training or groups on child-raising practices. Generally this literature focuses on interventions for the child with limited reference to child and family centred or parent psycho-education approaches. A theoretical occupational therapy approach forms the basis of the CCAP model. It incorporates theories of human development, together with the psychosocial and occupational needs of children and families (Cronin-Mosey, 1996; Cronin, 1996; Davidson, 1996; Keilhofner, 1995). Occupational therapists such as Wilcock (1998) have described the occupational health perspective. She outlines the biological needs of humans to engage in occupation, identifying four major functions. These are to provide for bodily need; to develop skills, social structures and technology; to maintain a healthy balance in life; and, to enable individual and social development. Two of these functions, individual and social development and skills achievement, were found to be useful in the CCAP model development.

A resource that has also been useful is the work of Cronin-Mosey (1996). She identifies the following occupational therapy tools of: purposeful activity, activity groups, teaching-learning processes, the conscious use of self, activity analysis and synthesis, the non-human environment as important components in mastery and role development, and the process of change for adults and children.

Many parents seen in child mental health services rarely experience the “flow-on” satisfaction (Cskiszentmihalyi, 1993) in their occupational role of parenting or their relationships with their children. They feel disempowered by the overt displays of their behaviour, and lack mastery or belief in their ability to change things (Hawley, 2002). The ability to engage satisfactorily in familial roles is a skill to be nurtured within each parent (Cronin-Mosey, 1996) ideally through interaction within the group and ultimately within the family context. CCAP offers the opportunity to develop parent potential, to gain mastery in the occupation of parenting and to improve child-parent relationships.

### CCAP group philosophy

Given New Zealand’s multicultural society (Bell, 1998; Davidson, 1996; Durie, 1984; New Zealand Association Occupational Therapy, 1998) differences in parental attitudes, beliefs and knowledge about parenting needed to be considered when developing the group philosophy. Brinson and Courtland (1997) who have provided guidelines for facilitating culturally responsive groups, emphasis trust building, rapport development and the sharing of differences in approaches to child raising. CCAP is offered to every parent irrespective of ethnicity. It is a dynamic group where emphasis is placed on parents nurturing their own particular “family culture” or traditional values rather than ethnic culture. Parents report this approach as helpful. It allows them to focus on child raising practices that work for them. An example of “culture” is reflected in the work of Dinkmeyer and Mackay (1997) that “if children are reared in an atmosphere of respect and cooperation, they are likely to adopt respect and cooperation as values and use them in other relationships” (p. 25). The CCAP encourages participants in the use of words such as kindness, honesty, patience, and truthfulness in daily conversations with children. This emphasises the values the parents may wish to portray to their children (Kavelin-Popov et al., 1995). It has been observed in the CCAP groups that these universal concepts work across cultures.

Parenting is a challenging task for any parent. The CCAP group recognizes that these parents require skills performed at a higher operating level, that is increased consistency and persistence combined with innovative ideas and strategies in parenting practices. CCAP group parents report feeling less prepared to meet the challenges of their particular child and over time they develop a negative perspective of their child-parent relationship. By the time they come to the Group they are often overwhelmed and disempowered. From the start facilitators emphasise the power of the collective knowledge within the group. As individuals we may not have all the answers, but in collaboration we can combine our knowledge to improve family relationships and management of children’s challenging behaviours.

## The CCAP manual and brochure development

The CCAP group uses a manual and referral brochure developed specifically for this purpose (Christie & Hedayati, 1999; Christie & Scaletti, 2000). The STEP programme formed the basis for the CCAP group and was gradually adapted over the years to meet our client needs. Following programme evaluation through the use of parent questionnaires developed by the facilitators resulted in the rejection of STEP manuals; audio and videotapes because they failed to meet their expectations perceiving them as unrealistic; that 10 sessions was too long. The development of the CCAP manual started in 1995 and was completed in 1999.

The CCAP manual (Christie & Hedayati, 1999) based on the work of Dinkmeyer and MacKay (1989, 1997) retains some STEP techniques and tools, but also includes other sources of literature on child development and child-raising practices that parents have reported works for them (Barkley, 1995; Baynard & Baynard, 1988; Birch, 1987; Coloroso, 1995; Kavelin-Popov et al., 1995; Marris, 1995; Saunders, 1996; Seymour, 1989; Webster-Stratton & Herbert, 1994; Wyckoff & Unell, 1984). The manual has clearly defined goals, for each session. These goals are supported by an educational component that includes examples of how to use the techniques or “tools”, homework tasks, a self-directed problem solving process or “toolkit” (see Table 1), and an evaluating system. It is a working model for the client to use throughout the group sessions and subsequently as a future reference or parenting guide.

Colleagues within the team are responsible for referring clients to the group. They report that the CCAP brochure is a valuable tool for encouraging this process. The brochure clearly outlines the programme, its content and what parents may expect to gain through participation, support of other parents and techniques to assist parenting practices. It advertises the course dates for the year and has a tear-off application form for parents to complete.

## CCAP facilitation and group process

Multidisciplinary team participation in CCAP group is encouraged. Staff orientation of new team members now includes an overview of group processes, referral structures and an invitation to attend the groups. All students on clinical placement are encouraged to attend CCAP and to use the strategies learnt within their own clinical practice. This is true for all team members who are invited to attend the sessions as a learning process, as an advocate for their client, to support parents in skills attainment who are not ready for a group experience, or to be a co-facilitator.

As a result of ongoing evaluation modifications were made to the programme in 1996 from 10 evening sessions to four weekly, two-hour daytime sessions concluding with a one session problem-solving day (PSD). It was initially thought that daytime groups would exclude fathers and working mothers thus reducing the attendance rate and minimising the effectiveness of the group. Evaluation of fathers' non-attendance at the groups showed they often babysat so mother could attend; or the parents attended alternate sessions sharing the babysitting task. Some families were unable to afford paid babysitters. The attendance ranges from 10 to 12 parents each session. Interestingly the introduction of day groups did not show less father attendance

but rather a shift to solo parents and families with high complex needs and mental health problems that resulted in dysfunctional family practices. Many commercial companies and businesses have a policy that allows employees, where applicable, health appointments during the day. This enables both working parents to attend daytime CCAP groups regularly throughout the year. In addition two facilitators have always been considered as a mandatory requirement for group management, maintenance of morale, consistency and evaluation procedures. A daytime group therefore made it easier for facilitators to run the group without compromising their own family commitments.

The PSD group supports the “toolkit” idea. It provides an opportunity for parents to refine or consolidate the application of ‘toolkit’ strategies learned, ensure consistency in parental practices and reinforce the feeling of empowerment and advocacy. Parents may attend as many groups as they wish. Repetition consolidates skills and endorses progress made with some families returning four and five times. The presence of past participants reinforces the process and validity of the group for newcomers. The content is arranged whereby parents may attend any particular session they have missed in order to catch up or review knowledge.

Emphasis is placed at the beginning of each group on parents describing their child and providing challenging behavioural “scenarios” that they wish to work towards overcoming. These scenarios are listed on the board as a visual reference. The “toolkit” idea is proposed and parents are given tasks that help them understand their children's behaviour from a developmental perspective. This helps begin the process of redefining the problem behaviours into a more positive context that empowers parents to become solution focused. The parents practise these tasks within the group then at home with their children, as it is not uncommon for children with mental health issues to have limited emotional repertoires (Saarni, 1999). This helps them to focus less on rewards and punishment and more on communication and collaborative problem solving thereby ensuring parenting becomes a more meaningful occupation. The communication component highlights the need for parents to help their children understand and recognise emotions, to give a name to their feelings extending emotional repertoires beyond the simply “sad”, “mad” and “glad” stage. Promoting effective communication through broadening the repertoire of parents' language encourages children's self-belief, and helps parents to explore alternative ways when expressing their ideas and feelings.

Humour can be used effectively when parents begin to share child-related problems. Humour is an integral part of the facilitator's interaction and an important component of the conscious use of self (Cronin-Mosey, 1996). Identified within individual group participants the use of humour is encouraged within the group. It is through humour that parents are able to share meaningful experiences about their children and relax sufficiently to join in the group interaction and activities. Farling's (1997) exploratory study concerning the use of humour and parenting practices identifies that humour appropriately used helps defuse potentially stressful situations. It

becomes a useful parenting strategy to help produce a cognitive shift in thinking with older children and adolescents. Parents are encouraged to use humour to capture their child’s attention (Grusec & Goodnow, 1994) when disciplining with respect, thus supporting the “culture” or values aspect of the family. Humour can also be used to distract the child from their behaviour thereby externalizing their behaviour as a problem for child and parent to collaborate and problem-solve. Humour helps create a balance between the extremes of emotion often expressed by stressed parents (Gilpin, 1993). It is through these social interactions in CCAP that parents are able to overcome their children’s challenges and ultimately gain pleasure from improved relationships with their child and family.

**CCAP group contents**

The development of the parental role focuses on education and practical applications of the “toolkit” (see Figure 1) with consideration of the cultural background of the parent or parents (Brinson & Courtland, 1997). The main objective of the group is to gain knowledge, understanding and practice in the skills learnt in each session. These skills include identifying the goals of misbehaviour in their children, using the communication

skills of encouraging language and reflective listening, exploring alternative strategies, natural and logical consequences instead of punishment, identifying who owns the problem and implementing family meetings. CCAP’s approach concentrates on helping the parent develop the skills necessary for adequate family interaction within the context of nonfamilial situations.

The two-hour session timeframe allows for the understanding of the session objective, participant feedback on homework tasks and the sharing of child experiences, social interaction (tea break) and encouragement to support each other in the task of parenting. Parental feedback on homework tasks is given priority at the beginning of every session. These everyday “behavioural scenarios” or illustrations are useful in consolidate the learning of each strategy or tool. This is when facilitators may pick up any discrepancies in the use of a “tool” and can assist parents to gain a better understanding. On occasion these illustrations may be targeted for further exploration. For the benefit of group learning this “scenario” may be followed throughout the four group sessions with additional tools being applied to demonstrate the sequential use of the problem solving formula or “toolkit” (see Figure 1). This parent input is welcomed as the programme manual is seen as a working and dynamic document.

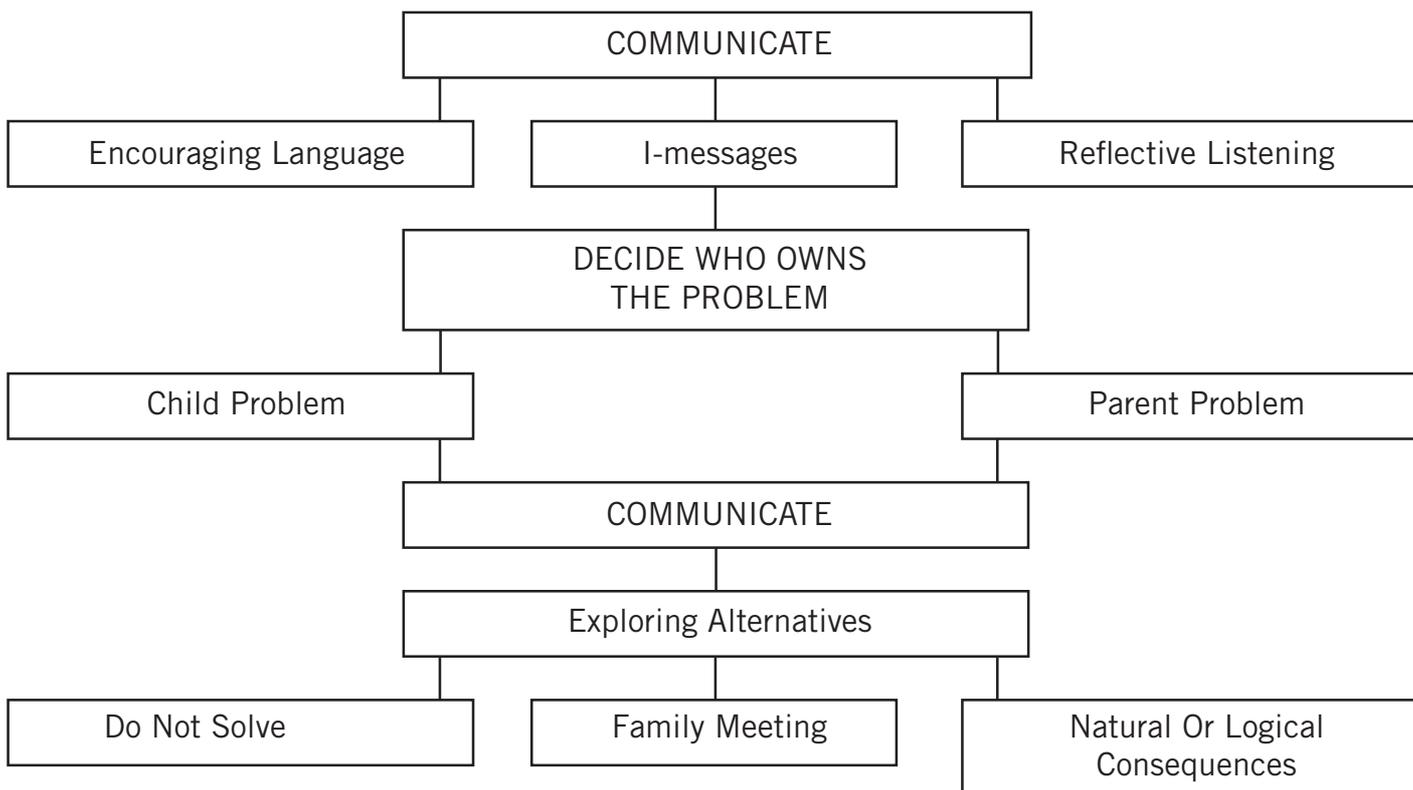


Figure 1. The Problem Solving Formula or ‘CCAP Toolkit’

Many of the scenarios are themes that run through each group such as morning routines, organisational issues, household rules, homework, food fads, swearing or lying, and sibling rivalry. These scenarios are not solved immediately. This requires all the tools to be understood and practised. By session four, parents are ready to put the “toolkit” together to problem solve the scenarios elicited in the first session. The parents leave with a working model for problem solving. It sometimes hap-

pens that these scenarios are no longer the main issue by session four. Parents become empowered to use the tools to good effect, so solve the problem themselves. Parents are encouraged to share these successes with the group, which adds further support to the validation of the programme philosophy.

A useful tool used by the facilitators is the art of reframing problems or situations with the parents. A recent study by Pololski and Nigg (2001) focused on “positive reframing”, a coping strat-

egy in which stressful experiences are redefined in order to make them more manageable. The results suggest important clinical implications on reducing parental stress, improving child behaviour and skill development. CCAP participants demonstrate that through learning to separate their child from problem behaviours, stressful events are redefined or reframed in realistic and positive terms such as challenges to overcome rather than unsolvable problems. Parents report finding themselves feeling less stressed and more satisfied with their parenting.

### What works for CCAP?

Evaluation of a group programme or finding out “what works” should include measuring the group process, activities and quality of the programme, assessing if the objectives have been met, long-term goals and outcomes achieved (Battaglia, 2001; Hawe, Degeling, & Hall, 1993). Over the years, a range of evaluation tools (see Table 1) have been developed and used (for an example, see Table 2). Reporting the results of these evaluations are beyond the scope of this paper.

Table 1.  
Evaluation tools developed and used for the CCAP programme.

1. CCAP Parent Evaluation (Christie & Hedayati, 1999). A scale rating parent satisfaction that evaluates content, learning objectives, homework and presentation.
2. CCAP Knowledge Gained (Christie, 1997). A measuring tool based on the Teler™ system (Le Roux, 2001) located at <http://www.teler.co.uk> (for an example, see Table 2.)
3. The Parenting Scale (Arnold, O’Leary, Wolff, & Acker, 1993). A self-assessment tool that measures discipline practices in parents related to three factors of discipline style: laxness, over reactivity and verbosity.

Perhaps one of the most powerful aspects of the CCAP group is the shared experiences and collaboration between facilitators and parents of the difficulties of parenting a challenging child. Collaboration provides credibility to the group process (Christie, 1999; Christie & Scaletti, 2000). In addition the use of humour and the art of reframing cannot be over emphasised as a useful adjuncts to the facilitation process as is the interactive, practical approach to dealing with child issues. Supportive friendships made within the group often continue long after the event. This is empowering. The perception of being able to return for further support, not because of parental failure, but because of the difficulties of coping with challenging behaviours of children, is a concept welcomed by parents. It is through empowerment and knowledge that parents become better advocates for themselves and their children.

### Conclusion

CCAP is open to all parents of children attending the Kari Centre. A certain percentage of these children present with a disruptive behaviour spectrum of disorders such as attention deficit hyperactive disorder and oppositional defiant disorder, as

Table 2.

An example of an evaluation: CCAP component objective, homework tasks, component indicators and measure for outcomes used to assist achievement of knowledge.

#### Objective Session 1:

To gain knowledge and understanding of behaviour and practise identifying the goals of misbehaviour and the communication skill of encouraging language.

#### Participants Homework:

1. Identify your child’s behaviour by expressing how you felt, what you did, what your child did, and name the goal.
2. Identify a time when your child pursued the goal of misbehaviour both PASSIVELY and ACTIVELY.
3. To use an encouraging phrase and name the situation where this occurred.
4. Report the above back to the group in the following session.

#### Component Indications:

1. Attend session.
2. Listen to what is behaviour and identify one of the four goals of misbehaviour.
3. To identify a goal of misbehaviour both active and passive.
4. Listen to what is encouraging language and use one of the phrases.
5. Feedback a verbal scenario of having used all of the above in an external setting.

#### Component Measure:

0. Unable to achieve any
1. Able to achieve 1
2. Able to achieve 2
3. Able to achieve 3
4. Able to achieve 4
5. Able to achieve all

well as a range of anxiety, mood and pervasive developmental disorders. The latter includes the autistic spectrum disorder. Relatively little is known about the strategies that parents of children with mental health problems use to cope with the unique challenges they face and whether particular strategies are associated with reduced stress levels. Many parents who attend CCAP often feel powerless. The empowerment process (Egan, 1994) is apparent when parents gain knowledge about their children’s behaviour and an awareness of the power of dynamics at work in their life context. They redevelop skills and the capacity for gaining some reasonable control over their lives and ultimately their children. These practices are performed with respect and caring, teaching their children skills for life and future independence. Further research in this area would be useful so that future parent education programmes could focus on those strategies or skills that work best for parents of challenging children.

CCAP facilitators believe the collaborative approach has provided a working model for fostering parent empowerment and parent-professional co-operation. The psychosocial adaptation of family members or of individuals significant to the child or ado-

lescent is often not given sufficient attention. The occupational therapy psychosocial component approach that includes those areas of human function that enable the individual such as a parent to adapt, is the theoretical basis used to underlie the CCAP programme. This approach and the use of legitimate tools of occupational therapy is thought to have provided the emphasis for change in the major occupational and social role of parenting and enhanced the interactive group process. Surely this eclectic (Cronin-Mosey, 1996) and multidisciplinary focus is potentially far more adaptive than a singular approach. Further research by occupational therapy into the value of groups based on diverse orientations and points of view would be a useful resource for our profession, given the paucity of literature in this clinical area.

Generally the CCAP group reflects the consistency of leadership, evaluative systems and literature-based programme. Co-facilitator's like parents, bring fresh ideas and strategies to the group. This collaboration between parents, colleagues and the six co-facilitators has made valuable contributions to the success of the CCAP programme. The next development planned will be the promotion of a supplementary manual of useful information, such as managing homework issues, as an adjunct to the CCAP Manual.

## Acknowledgements

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## Key points

- Development of a long running, consistently evaluated, literature-based programme.
- Collaborative model of group intervention that encourages democracy, self-advocacy, empowerment and client-professional co-operation.
- A "toolkit" for problem solving children's challenging behaviours.
- Objectives met through the development and use of a range of evaluating tools.

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## Commentary to “A programme for parents of children with challenging behaviours: An occupational therapy approach”

Merrolee Penman

Penman, M. (2003). Commentary to “A programme for parents of children with challenging behaviours: An occupational therapy approach.” *New Zealand Journal of Occupational Therapy*, 50(1), 17.

It is a pleasure to write a commentary to the above article. The authors are to be congratulated on their willingness to share what appears to be a very effective group programme in a manner that allows peer review.

Although Christie and Hedayati (2003) specifically state that it is not their intention to make comparisons with similar programmes, it is possible with the depth of this article for readers who may be running parenting groups, to consider and compare their own group against that described in the article. This process allows for informal evaluation, which is one of the ways that occupational therapists can be confident about the effectiveness of the interventions they offer. The Challenging Children and Parenting group (CCAP) has been developed over a period of 15 years. The quality that occurs with this long period of ongoing evaluation and modification cannot be underestimated and it is important that this is shared with other occupational therapists who may be in the process of developing their own groups to address parent needs.

I noticed the authors attempt to articulate the theories on which the CCAP was founded and developed. This is one of the strengths of the article and I believe that this article may prompt the reader to consider just how well they could articulate the theory base that informs their decision-making? I was also challenged to think about the needs of parents who have children with a disability, that is not mental health in origin. Christie and Hedayati describe the challenges that parents face. My own experience of working with parents of children with physical disabilities which is supported by authors such as Humphry and Case-Smith (1996) leads me to believe that programme similar to the CCAP group would be beneficial for

all parents of children with disabilities. While parents needs are acknowledged and are at times the focus of intervention, would a group such as CCAP offer much for the parents of children with any disability, not just children with a mental health disorder? Another aspect of the article, which might challenge some of our notions how to work with parents, was that of the use of humour. The authors' descriptions of how they use humour in a therapeutic way encouraged me to feel more confident that humour can be a useful adjunct to addressing behavioural issues in this context.

There were many parts of the article that encouraged me to reflect on my practice, but the one I wish to emphasise the most was the value that the authors placed on the importance of collaboration with parents, and between parents. The importance of families as partners has been outlined by Cermak and Larkin (2002). Christie and Hedayati provide good reminders of what it means to truly engage in a ‘parent-professional relationship’ and how this contributes to the effectiveness of interventions.

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# A fitness and lifestyle programme for people with psychotic disorders

Chris Lloyd, Dan Sullivan, Nicole Lucas and Robert King

## Abstract

People with psychotic disorders may experience a number of risk factors which impact on their lifestyles, health, and quality of life, notably low income, poor dietary patterns, smoking, lack of exercise, and medication side effects. They are at high risk of many physical illnesses which could be reduced by implementing health promotion programmes targeting fitness and lifestyle issues. A fitness and lifestyle programme for clients with psychotic disorders was designed and implemented by occupational therapists in a regional mental health service. The programme involved structured physical exercise and educational sessions addressing lifestyle change, health benefits, recommended exercise and activity levels, goal setting and monitoring outcomes.

## Key words

Weight gain, fitness, health promotion, programme evaluation

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## Introduction

Abnormal weight gain is a side effect of many psychotropic medications such as clozapine, olanzapine and risperidone (Malhi, Mitchell, & Caterson, 2001). Weight gain is distressing and impacts not only on the general physical health of the person, but may also result in the person being further stigmatised and discriminated against in daily life because of being overweight (Blin & Micallef, 2001). In addition, it may impact on the mental health and emotional well being of persons with psychotic illness (Blin & Micallef, 2001). Weight gain may be viewed as an undesirable effect and may have a potentially negative impact on the person's overall health and treatment compliance (Basson et al., 2001). Research has indicated that weight gain was rated by clients as the most distressing of adverse effects listed and the most likely to contribute to poor compliance in the future (Blin & Micallef, 2001). In the general population, being obese or overweight confers a significant increased risk of developing many medical diseases, for example, diabetes, ischaemic heart disease, hypertension, stroke, gall bladder disease, and some cancers (Malhi et al., 2001). Lawrence and Coghlan (2002) have found that persons suffering from psychotic illnesses are two and a half times more likely to suffer premature death from physical causes than the general population. Researchers have concluded that clinicians should be aware of the potential liability of novel anti-psychotics and have recommended that clients should have nutritional counselling and referral to exercise programmes while taking these medications (Blin & Micallef, 2001; Wirshing et al., 1999).

The purpose of this article is to discuss the development and implementation of a rehabilitation programme designed to address weight gain and lifestyle issues experienced by people with psychotic disorders.

## Literature review

### Fitness and lifestyle programmes

Fitness and lifestyle programmes have many benefits for clients of mental health services. Possible benefits to participants are improved self-esteem, increased activity levels, increased range of activities, increased fitness, weight loss or maintenance of current weight (Fox, Boutcher, Faulkner, & Biddle, 2000). The literature has reported that regular physical activity enhances self perception, quality of life, mood states, levels of concentration, and emotional well being and body image (Biddle, 2000; Fox, 2000; Paluska & Swihwenk, 2000; Wigg, 2000). Additional benefits include increased compliance with treatment. This has implications for long-term outcomes because compliance with treatment is one of the factors that determine the degree of success of antipsychotic treatment (Blin & Micallef, 2001). As noted in the research, clients who fail to take their medications as directed have a poorer long-term outcome, suffer more frequent and more severe relapse, and make more demands upon their families and rehabilitation services (Blin & Micallef, 2001).

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It has been found that traditional methods of prescribing exercise have not proven effective for increasing and maintaining a programme of regular physical activity (Dunn et al., 1999). Dunn compared the 24-month intervention effects of a lifestyle physical activity programme with traditional structured exercise on improving physical activity, cardiorespiratory fitness, and cardiovascular risk factors. Results indicated that both the lifestyle and structured activity groups had significant and comparable improvements in physical activity and cardiorespiratory fitness from baseline to 24 months.

In the study conducted by Unger, Skrinar, Hutchinson, and Yelmokas (1992), they found that following participation in a fitness programme, outcomes included a slight decrease in body fat, an increase in cardiovascular fitness, and positive attitude changes. Cole (1998) found that participation in an exercise group leads to greater reduction in overall psychiatric symptomatology. According to Pratt (1999), there are a wide variety of types, intensities, and patterns of physical activity that provide meaningful health benefits. He suggested that, depending on initial fitness, health status, personal preferences, and lifestyle, any of several physical activity choices may be the right one for a given individual. A review conducted by Ross, Freeman and Janssen (2000) concluded that exercise alone is an effective strategy for reducing obesity and related co-morbidities.

### Un-met physical health needs

Increasing physical activity in populations at risk for inactivity has been identified as an important public health challenge (Ministry of Health, 2000; Taylor, Barranowski, & Young, 1998). Byrne, Isaacs and Voorberg (1991) conducted interviews with 73 clients who had a history of chronic mental illness. The findings revealed unmet physical health needs. The researchers recommended that these individuals are in need of health promotion programmes to foster healthy behaviours and lifestyle choices. Liberman and Coburn (1987) concluded that clients and service providers must be better educated on the importance of physical health and health care behaviours in managing psychiatric illness. The evidence for exercise and mental health exists, however, it has not been widely accepted into practice (Fox et al., 2000). Fox suggested that exercise is an exciting and untapped intervention within the growing field of mental health promotion.

### Occupational therapy

Suto (1998) argued that further theoretical development of leisure concepts and their application to occupational therapy needed to be developed. She believed that this will strengthen the knowledge base upon which occupational therapists plan interventions with clients. There is some evidence that occupational therapists can implement fitness-oriented programmes. For example, physical activity intervention for clients with substance misuse problems (Ussher, McCusker, Morrow, & Donaghy, 2000); exercise classes for older adults (Moore & Bracegirdle, 1994); and jogging with depressed adolescents (Brollier, Hamrick, & Jacobsen, 1994). These interventions were found to have an impact on the lives of the people participating

in them and highlighted that occupational therapy can play a pivotal role in promoting fitness-oriented physical activity programmes.

Reynolds (2001) stated that health professionals often miss opportunities to raise issues of physical activity and exercise behaviour with their clients and, therefore, do not promote health in its broadest sense. She suggested that occupational therapists are well placed to incorporate health promotion within their interventions in mental health settings, facilitated by a client-centred approach that considers the client's needs and lifestyle in holistic terms.

### Programme design

Kausman (2000) suggested that there needed to be a change in perspective to long term weight management. This process needs to be empowering for the individual and involves working on why specific issues have become a problem for that person. According to Wigg (2000), losing weight is a very complex issue and process. She recommended that the main focus should be on the physical and psychological health benefits of adhering to regular physical activity and that any weight loss should be seen as a by-product of the healthy lifestyle. Clients are empowered to understand how their behaviours are related to a healthy lifestyle when they are educated about the health benefits of physical activity and are taught to focus on these benefits. Reynolds (2001) advocated using a health promotion perspective in facilitating physical activity and wellbeing. Strategies that have been shown to be effective included educational interventions, exploring barriers to physical activity, promoting self-efficacy for exercise, maximising rewards, encouraging goal setting, relapse prevention, social support, and prompts to action (Reynolds, 2001).

### The fitness and lifestyle programme

Based on identified needs of clients of a regional mental health service, a fitness and lifestyle programme, focussing on structured physical activity, was developed to address the issue of weight gain as a result of psychotropic medication.

### Programme description

The current programme was implemented in early 2002 with three rehabilitation staff members facilitating the group. The group is conducted weekly at the Sanctuary Cove gymnasium. This venue was chosen due to its modern facilities and the fact that the proprietors offered the participants of the group an attractive admission rate. The gym supplies the services of a personal trainer who guides participants through a course of aerobic exercise, weight training, and yoga. In addition to this the rehabilitation staff members deliver education regarding dietary intake, the need for exercise outside the structured activity times and the types of exercise that are most likely to be of benefit to achieve their goals. Transportation is offered to the venue from the Gold Coast Hospital and back for those participants without the use of a private vehicle.

Referrals are received from consultant psychiatrists, inpatient nursing staff, and community case managers. Participants

are those clients who were on novel antipsychotic medication and had experienced abnormal weight gain. An assessment process occurs for each referral. The assessment explores the person's life roles, impact of illness on functioning, strengths, areas he or she would like to work on, and goals. Following the assessment, clients are referred to a group programme that would best meet their identified needs and goals. Clients are referred to the structured physical activity programme, if they have the following goals –

1. To maintain or reduce weight
2. To increase fitness levels, and
3. To increase physical activity levels.

There are 11 participants in the current programme, seven of these are male and four are female.

### Programme evaluation

Programme evaluation is an essential process. There is an expectation that programmes achieve what the stated goals are and that positive client outcomes are obtained. Four main forms of evaluation are being used for this programme. Firstly clients' goal attainment is assessed, and secondly measurements of percentage body fat, weight and basic physical observations such as resting pulse rate are taken and measured at three-weekly intervals. An assessment is made of participants' activity levels to determine if they have made changes in the amount of physical activity they undertake (National Center for Health Statistics, 1973). Finally, a measure of global psychological responses to the stimulus properties of exercise is taken (McAuley & Courneya, 1994).

Clients have stated they have benefited by embracing a feeling of hope after having seen their level of fitness increase both in strength, aerobic endurance, and reduced percentage body fat. Group members have also stated they find it "enormously therapeutic" to realise that other persons with mental illness are facing the same physical challenges as themselves. Another important aspect is that of building partnerships with the mainstream community. This is less stigmatising and assists in the process of integration into the community for this client group who experience disadvantage in successful community living.

### Case studies

To illustrate the evaluation process, two case studies have been chosen. Names have been changed to ensure confidentiality. Preliminary findings have shown improvement for most participants in at least one area of physical health (reduced percentage body fat, reduced weight or lower resting pulse rate) and increased activity levels. The remaining clients in the programme have shown less significant improvements. Although, it should be noted that weight maintenance is one of the goals of the programme and that these clients had not put on additional weight during this period.

Tom is a 42-year-old male with a diagnosis of bipolar affective disorder. He is single, lives with his family and is on a disability support pension. He has his own car so has independence in going places. Tom had very few leisure interests and did not carry out regular physical activity. His goals on

joining the programme were to lose weight and to feel more fit. Alan is a 31 year old male with a diagnosis of schizophrenia. He is single, lives in supported accommodation, and is on the disability support pension. Alan is dependent on other people to give him lifts so had limited access to community resources. At the time of referral to the programme, Alan had few leisure interests, low levels of physical activity and did not feel fit. His goals were to increase muscle bulk and strength and to become more fit. Both were taking atypical antipsychotic medication.

At the time of the evaluation, Tom and Alan showed a reduction in waist measurement over the initial 10-week period of the programme of approximately 4%. The same two clients have shown a reduction in weight over the same period (see Table 1). The amount of walking Tom did had increased from one to three kilometres per day, there was an increase in light activity such as strolling and a reduction in time spent doing sitting activity such as watching television. He identified that he would like to take up more activity. Tom reported that he thought he was performing things well and experienced a feeling of satisfaction with being more active. Alan reported that he was undertaking different levels of activity. He was undertaking regular walking and walked approximately six blocks on a daily basis. In addition, he had taken up ten-pin bowling on a weekly basis. Alan reported that he was feeling good about himself now that he was keeping himself busy. He identified that he would like to take up more exercise, to continue to increase muscle bulk and strength, and further increase his fitness level.

Table 1.  
Waist and weight measurements.

Client	Waist CM1	Waist CM2	KG1	KG2
1	110.50	105.00	93.20	88.50
2	113.50	108.00	96.10	93.40

### Discussion

The effect of atypical psychotropic medications on weight is an important but complex issue. The subject requires more attention by occupational therapists. The authors of this article believe that, since occupational therapy has traditionally advocated the use of purposeful lifestyle activity, attention should be paid to those factors which impede an individual's lifestyle. Lack of compliance and deterioration in physical health status may be influenced by weight gain. The journey to recovery can be difficult and fraught with set backs. As we have seen, weight gain can be one of these setbacks with associated stigma, reduced fitness, physical health risks and has a negative impact on a person's sense of wellbeing. Occupational therapists need to work with clients on their journey to recovery and address lifestyle issues in their fullest sense. This means taking an approach that integrates physical health with mental health.

The clients in this programme showed either noticeable reduction in weight, percentage body fat and waist measurement or stopped putting on additional weight. Studies such as the one conducted by Ball, Coons and Buchanan (2001) which

looked at dietary interventions to address atypical antipsychotic related weight gain found that males are more responsive to the intervention. It is interesting to note that the two clients in this programme who improved most were both male.'

Whilst addressing the physical issues of weight gain resulting from atypical antipsychotic drugs, the programme is additionally targeting psychological issues associated with these gains, such as poor self-esteem, poor sense of well-being and decreased quality of life. It is through this structured activity programme that outcomes of weight loss can foster a healthier self-esteem, sense of wellbeing and quality of life in clients. Furthermore, these positive changes in a client's physical and emotional wellbeing can have a positive therapeutic effect across all aspects of a client's life, such as social or vocational.

Those clients incorporating physical activity into their routine outside the structured programme were more likely to show measurable improvement. In keeping with the literature, regular physical activity should be undertaken twice a week and lifestyle activities, such as walking add to the level of daily physical activity which contribute to increased fitness levels (Ministry of Health, 2000; Wigg, 2000). It is for this reason the authors recommended increasing the gym component in any future programmes of this type and reinforcing client participation in low cost community-based activities, such as walking on the beach. The programme is currently being evaluated more extensively, to determine changes in physical activity levels, specifically, how physically active the person was, the amount of exercise the person did, the amount of walking or jogging, the types of recreation, sports or physically active hobbies and dietary intake the person had undertaken. This will provide useful information for practitioners and further inform the continued development of lifestyle programmes by occupational therapists.

With the direct therapeutic impact and positive secondary outcomes resulting from a single structured physical activity programme, occupational therapists employed in any mental health setting should seriously consider incorporating such a physical programme into their service. The evidence has shown that people with a mental illness have unmet physical health needs (Byrne et al., 1991; Coghlan et al., 2001) and that physical activity as an intervention is important in achieving health outcomes (Ross et al., 2001). As has been noted physical activity interventions in mental health have not been widely adopted (Fox et al., 2000), therefore, the opportunity exists for occupational therapists to take a proactive role in developing such health promotion programmes.

## Conclusion

The preliminary evaluation of this programme suggests that there are potential benefits available to those persons taking atypical antipsychotic medication by undertaking regular exercise. Those benefits include reduced percentage body fat, reduced weight or maintenance of current weight, improved aerobic endurance, lower resting pulse rate and increased self esteem and quality of life. Physical activity programmes are a valuable health promotion strategy that contribute to improved

physical health status and wellbeing. To more fully address the health needs of clients with a psychotic disorder, physical activity programmes should be included as part of their overall treatment regimen. The challenge ahead for occupational therapists is to promote the more widespread adoption of such programmes. Future directions that should be focussed on include developing physical activity concepts in relation to occupation, providing guidelines for occupational therapy practice, and evaluating the programmes that are implemented.

## Key points

- People with mental illness have poorer health status than the general population.
- The mental health system has failed to meet the full health needs of people with a mental illness.
- Health promotion programmes need to be implemented to foster healthy behaviours and lifestyle choices.
- Fitness and lifestyle programmes developed by occupational therapists contribute to improved health status and quality of life.

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# Adventure therapy in occupational therapy: Can we call it spiritual occupation?

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## Abstract

This paper looks at the theoretical underpinning of both adventure therapy and occupational therapy, and the way activities designed to generate personal change can be used by occupational therapists. It will address aspects of adventure and occupational therapy in an attempt to initiate discussion, development and documentation of the use of adventure activities in occupational therapy. It puts forward an argument that adventure activities address the spiritual performance component of people and therefore have a significant place in occupational therapy's repertoire.

## Key words

Canadian Model of Occupational Performance, spirituality, performance component

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## Introduction

Within some areas of rehabilitation in New Zealand today, there is a growing enthusiasm for the use of adventure therapy. In this context, adventure therapy refers to the use of adventurous activities such as kayaking, abseiling, high ropes and rock climbing which often take place in an outdoor setting or natural environment, and are applied in a considered way to facilitate a therapeutic benefit such as the development of personal growth, confidence and life-style satisfaction. Many health professionals, including occupational therapists, are taking clients into outdoor locations so they may take part in activities which are not necessary to their day to day occupational performance. In the past occupational therapy has emphasised functional restoration of skills, and the development of independence

(Crabtree, 1998), but adventure therapy activities are not generally thought of as being necessary to normal everyday occupational needs. Can occupational therapists therefore, legitimately involve their clients in activities which are not directly related to activities of daily living or productivity, and are not necessarily considered leisure activities, which are defined as activities which have been freely chosen for the satisfaction they bring (H. Blijlevens, personal communication, January 30, 2003), and still say they are practicing occupational therapy?

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This paper is written to consider the two disciplines of adventure therapy and occupational therapy, and to examine the applicability of adventure therapy to two of the client groups that occupational therapists work with: people with mental health illness (Roberts, Horwood, Auger, & Wong, 1997), and people with spinal cord injuries (Taylor & McGruder, 1996).

In bringing adventure therapy and occupational therapy together, it is necessary to consider what occupational therapy and adventure therapy are and whether there is a therapeutic potential in adventure activities. Do adventure therapy philosophies and beliefs fit with occupational therapy philosophy and models of practice and beliefs about how change occurs; do these activities enhance the practice of occupational therapy, and what performance component is affected by taking part in adventure therapy activities?

While occupational therapists may work with clients to solve their occupational difficulties and limitations in a very practical and direct way, in both the psychosocial and physical fields, motivational and spiritual aspects also play an important part in occupational performance. This is true of people with physical as well as mental health disabilities, as long term physical disability may have severe psychological or mental health implications, which may affect mood and motivation. Addressing underlying depression or negative feelings of self worth in all clients can directly impact on their motivation to participate in the rehabilitation process (Taylor & McGruder, 1996).

Most people do not need to scale a rock face or paddle a kayak as part of their daily activities, yet the power and potential of these activities for bringing about change in clients' ability to live in the world has been asserted. This raises the question, what performance component of a person is affected by these activities? The Canadian Model of Occupational Performance (Canadian Association of Occupational Therapists, 1997) places the client at the centre of the model, and names the four performance components of a person. They are the physical, affective and cognitive aspects, and at the heart of these, the spiritual aspect of the person. Spirituality is regarded as a performance component (Urbanowski & Vargo, 1994) and is recognised as having a profound motivating and integrating effect on people's actions (Peloquin, 1997). As a performance component, it has been suggested that the spiritual aspect of a person is subject to illness and disability as are the other three performance components (McColl, 2000). This paper maintains that it is the spiritual aspect of the person that is affected by participating in adventure activities. As change in the efficacy and impact one has on one's life, must change the meaning by which one understands one's life, it is suggested that these activities be known as "spiritual occupations".

The debate on whether spirituality can be described distinctly from religious belief has drawn in a number of authors within occupational therapy (Christiansen, 1997; Howard & Howard, 1997; McColl, 2000; Unruh, Versnel, & Kerr, 2002), and while it is impossible to consider oneself a religious person without also being a spiritual person, many would argue that it is possible to be spiritual without being religious (Howard & Howard, 1997). It would therefore seem that everyone has the

capability to be a spiritual person, while not necessarily being actively religious. This paper adopts a secular perspective of spirituality, whereby spirituality is considered to be at the centre of each person (Christiansen, 1997; Howard & Howard, 1997; McColl, 2000; Mc Donald, 2001; Peloquin, 1997; Reibero, 2001; Unruh et al., 2002; Urbanowski & Vargo, 1994), therefore the thoughts contained in this paper can apply to all people, whereas a religious perspective may not.

Considering the spiritual element of therapeutic interventions is particularly relevant in New Zealand because of the emphasis on spirituality within Māori models of health. *Whare Tapu Wha*, the Māori model of health described by Durie (1989), is based on four aspects of health, *Taha wairua* (spiritual), *Taha hinengaro* (mental), *Taha tinana* (physical) and *Taha whanau* (family). *Taha wairua* is considered the most important aspect as it permeates all aspects of Māori life and implies a capacity to be able to understand the links to one another and the environment (McDonald, 2001).

With Māori over-represented in all health and corrections figures (Patel, 1992; Potaka-Dewes, 1988), a model of health which applies equally to Māori and non-Māori will ensure an acceptance by both populations and a good fit between health beliefs and practices. For these reasons, adventure therapy activities, which as this paper asserts affects the spiritual performance component, may prove to be particularly well suited to young Māori people, who may be experiencing a "spiritual dislocation" brought on by the separation of needs and their fulfilment in 21st Century urban life, and who appreciate the real challenges to their physical, emotional and spiritual being that adventure activities bring.

## Defining occupational therapy

Occupational therapy is a profession that enables people to lead meaningful and satisfying lives through participation in occupation (New Zealand Association of Occupational Therapists, 2002). This definition, adopted by the New Zealand Association of Occupational Therapists, implies a client centred position in which clients are recognised as being the experts about themselves, and therefore know what they want and need to do, but are unable to do. Occupational therapists are those professionals who use purposeful and meaningful activities to restore underlying capacities and to develop meaningful occupations (Fisher, 1998). Occupational therapy is the therapeutic use of occupation to improve people's health and quality of life by enabling them to do the occupations they need and want to do in their everyday lives in order to make life meaningful and satisfying.

Occupation has been defined by the Canadian Association of Occupational Therapists (1997) as "activities or tasks which engage a person's resources of time and energy; specifically self-care, productivity and leisure" (p. 140). Keilhofner (1995) expands the definition by describing human occupations as "doing culturally meaningful work, play or daily living tasks in the stream of time and in the contexts of one's physical and social world" (p. 3). Or as Law et al. (1997) simply suggest, "it is everything people do including looking after oneself, enjoying life and contributing to others" (p. 23).

Occupational therapists believe that engagement in occupation is basic to what makes us human and that it is restorative or healing in its own right (Meyer, 1922). It is through involvement in occupation that we develop our human potentials. Wilcock (1993) maintains that our identity as individuals is developed through the occupational choices we make, and that our health is affected by the occupational choices we make in response to our inner urges and needs.

Occupational therapy can be applied to a wide range of impairments and disabilities, but the basic beliefs that underpin the profession remain constant – that all illness or disability affects our ability to perform the daily occupations that we need and want to do. Conversely occupation can be prescribed therapeutically to enhance functioning and remediate against illness or disability.

This view of the purpose of occupational therapy differs from the long held belief that the aim of occupational therapy was to improve functional performance, in particular the restoration of independence (Crabtree, 1997). While this was seen as occupational therapy's primary goal, prescribed activities often focused on the development of aspects of physical or cognitive function, and could at times be mechanistic or divorced from the client as a holistic being.

In taking a fresh look at the outcome of occupational therapy intervention, Crabtree (1998) argued that the end result of occupational therapy intervention "is to help people with performance deficits make and express meaning through occupation" (p. 205). He asserts that human beings are meaning makers, and that they make and express meaning through their performance as well as through their cognitive activities. Moreover, making meaning through performance is constitutive of who we are. As human beings we attribute meaning to our own and others activities, and it is through our actions that we express what we mean and who we are. Making meaning in everyday activities is considered the essence of spirituality (Urbanowsky & Vargo, 1994).

Occupation is a noun of action, the action of seizing, taking possession of or occupying space and time (Fisher, 1998). The unifying criteria which can be applied to all activities in occupational therapy is the action component, "doing" is the primary intervention process. Kielhofner, (1995) states that "doing" is the central feature of the domain of behaviour we refer to as occupations. Using this definition and the notion of participation, adventure activities can well be considered legitimate occupations within the scope of practice of occupational therapy.

## Defining adventure therapy

Adventure therapy is the use of adventure activities to enhance established treatment objectives and to provide a richer therapeutic environment for change, so that therapy is more successful (Gass, 1993). Gillis and Ringer (1999) define adventure therapy as the "deliberate, strategic combination of adventure activities and therapeutic change processes with the goal of making lasting changes in the lives of participants" (p. 29). They go on to state that adventure provides a concrete, action-based, experi-

ential medium for therapy, and that the specific activity used is chosen to achieve a particular therapeutic goal. It is assumed from these words that the changes that are made in the lives of clients are of a psychological or spiritual nature rather than functional performance that has been the major purpose of occupational therapy in the past fifty years.

Adventure therapy uses a wide spectrum of activities primarily intended to bring about changes which support meta-level behaviours (Itin, 1997). These are generally thought to encompass motivation, confidence, co-operative behaviour, risk taking and self-reliance. Adventure therapy activities take place in tandem with reflective group activities to concretise and emphasise the achievement of therapeutic objectives.

Adventure therapy is based on the principles of experiential learning which maintain that learning or behaviour change must focus on direct experience as the basis of change. Experiential learning is a dynamic process in which the participants are actively involved, and often requires problem solving, curiosity and reflection (Gass, 1993). Adventure therapy programmes differ from general purpose adventure programmes in that they focus on creating circumstances likely to engender specific change in participants (Gillis & Ringer, 1999).

In adventure therapy challenge, extending boundaries and overcoming fear are seen as some of the central reasons why these activities bring about change. In many cases the adventure therapist designs the activities with client input, and the clients are encouraged, but never forced, into taking part in them. Often this takes the form of reasoning with the client around the perceived risks and their anxieties. In adventure therapy the perceived risks are always higher than the real risks, but "challenge by choice" is a principle that is always applied.

From the occupational therapy literature, Kinsella (2001), quoting Kolb, proposes that experiential learning occurs in a cyclical fashion, in that, beginning with a concrete experience, we reflect on it, conceptualise or theorise about the meaning of the experience, then test out new understanding in the world in action. In this way experiences become avenues for new learning and development. Many adventure therapists base their interventions on Kolb's experiential learning cycle.

Adventure therapists maintain that experiential learning takes place and generally positive change occurs when people are placed outside of their comfort zone, into states of dissonance which need to be resolved in order to reach equilibrium. New ways of behaving and responding are required of the participants, and accepting this challenge necessitates change with its resultant growth and learning. Several elements are inherent in this process and it is here that the alignment of adventure therapy with occupational therapy is clearly evident. These are that –

- The client is a participant rather than a spectator
- Therapeutic activities require client motivation in the form of energy, involvement and responsibility
- Therapeutic activity is real and meaningful in terms of natural consequences
- Reflection is a critical element of the therapeutic process, and that

- Functional change must have present and future relevance for the client.

## Adventure therapy process

Understanding how change occurs enables the therapist to more confidently and accurately plan for these changes to take place. One of the cornerstones of adventure therapy is to encourage people to do things they might not usually do. In doing so, unique insights and outcomes may emerge. Clients are asked to leave their comfortable surroundings and patterns of behaviour, and participate in new activities which are designed to bring up feelings that will disturb them, and they do this because they can perceive that these adventures will fill a need within them. Clients are asked to trust the therapist who will put experiences in their path that will help them find new inner resources and which will enhance self-esteem. It is believed that by integrating these resources and feelings to their life they will be assisted to live more satisfactory lives in the community.

Central to this is the ability of the client to break through from their comfort zone to the risks and successes of new territory. Although it is important to encourage breakthroughs for the client, learning what happens at the “edge” between breakthrough and retreat is crucial for the generalisation and transference of experiences (Nadler, 1993). This is undertaken during the reflective process where personal experience is examined in depth.

Nadler (1993) describes eight stages in the adventure therapy process.

1. **The client.** He/she experiences an internal state which may be one of anticipation and excitement, or one of anxiety, but this internal state allows for disequilibrium.
2. **Disequilibrium.** This is a state of internal conflict which provides the motivation for the client to make changes. By involvement in experiences that are beyond their comfort zone, and a realisation that previous skills will not be adequate in this experience, individuals are motivated to integrate new knowledge or reshape existing perceptions.
3. **Novel setting.** Adventure therapy takes place in a unique physical and social environment, and the combination of unfamiliar physical activity plus immersion in a group of strangers, results in a heightened sense of arousal.
4. **A co-operative environment.** It fosters co-operative learning enables clients to experience a supportive atmosphere in which group cohesiveness develops.
5. **Unique problem solving situations.** New skills and problems solving opportunities are introduced to the clients in a sequence of increasing difficulty, (activity grading) which when solved by drawing on mental, emotional and physical resources lead to feelings of accomplishment.
6. **Feelings of accomplishment.** Success leads to increased self-esteem and belief in oneself, improved communication skills and more effective problem solving skills. The meaning of these is augmented by processing the experience.
7. **Processing the experience.** Clients are encouraged to reflect and express the thoughts and feelings they are experiencing.

Awareness of what they thought and did before retreat or breakthrough is essential if there is going to be generalisation and transfer.

8. **Generalisation and transfer.** It is about integration of new knowledge and behaviours into their lifestyle when they return home (Nadler, 1993).

Nadler (1993) goes on to state that the two factors that have been identified as separating adventure therapy from other therapies are dissonance and the unique environment in which therapy occurs. He also identifies six conditions that assist a client to adjust to the experience and which can be used by the therapist to accentuate disequilibrium and bring about change. These are –

### Hope

This condition exists when clients view the adventure experience as a way to solve or eliminate their problems or heal them. There is an expectation of a positive outcome. Hope is an integral part of the recovery model used in mental health (Roberts et al., 1997).

### Effort

This condition allows each client to focus on physical, emotional and mental abilities in the therapeutic experience to provide motivation for change to occur.

### Trust

This condition is the result of appropriate reliance and confident dependence on others, one’s self, the leader and the experience. The more trust that exists from these four sources the easier it is for clients to make focused efforts during tasks or endure the tension of being in disequilibrium.

### Constructive level of anxiety

When anxiety exists, individuals may experience ambivalence, confusion, discomfort, frustration and stress. The therapist’s role is to use this anxiety to achieve a positive therapeutic outcome. The impulse to reassure clients or to minimise their anxiety should be avoided, but managed by the therapist to assist clients to dismantle dysfunctional or limiting behaviour and progress towards functional change.

### Sense of unknown or unpredictable

Individuals often have a sense of awe or mystery about what they are going to experience, and in general should be encouraged to accept their feelings of uncertainty. The therapist should avoid dispelling disequilibrium by answering all their questions.

### Perception of risk

In most adventure therapy activities there is often a greater perceived rather than actual risk. One of the major focuses of processing can be to help clients to understand how they can overcome their own perceived risk and how they can transfer this learning to other perceived risks in their lives.

When adventure therapists understand the therapeutic conditions of change, and the factors that lead to change, they can

individualise each activity for each client to facilitate this change. This could mean lowering the anxiety level for one client while heightening it for another. It requires that the clients are appropriately assessed, the activity well analysed and that the therapist understands the process of change. A “just right” challenge will lead to growth and development.

### Recognising the importance of environment

Both occupational therapy and adventure therapy share an understanding of the importance of the environment as one factor in the success of therapy. Occupational therapists recognise three equally contributing factors to occupational performance; the occupation, the person and the environment. Shifts in any one of these three parameters will influence the way the occupation is performed. Adventure therapists recognise that the environment in which adventure activities take place is one of the most significant factors in requiring people to change and adapt.

Traditionally adventure therapy has taken place out-doors, in the wilderness, where many factors contribute to its potency. The wilderness has been seen as a restorative place (Miles, 1993), with psychological benefits which come as a result of effortless attention to one’s surroundings. People experience a sense of enjoyment in being in a natural environment, and may experience a sense of tranquillity which leads to reflection and contemplation. People can find themselves in touch with nature in which they feel a sense of union with something that is lasting, that is of enormous importance and that is larger than they are. They tap into a spiritual dimension that can be challenging, nurturing and healing.

Today adventure therapy has been adapted to fit many differing therapeutic situations, though few take place in remote areas (Gillis & Ringer, 1999). Gass (1993) describes adventure-based therapy, which centres on team games, problem solving initiatives and challenging activities. These often take place near the facility from which the clients come, or a specially designed adventure location. Whichever location is used, programmes need to be designed with the specific needs of the client population clearly in mind, taking into account other resources such as other staff availability, financial support and time.

### Using adventure therapy with two client groups

While there is much published in the adventure therapy literature on all aspects of the profession including its underlying philosophical base and ways it can be used with a wide variety of clinical groups, there is little in occupational therapy literature on the use of these activities. Two articles were chosen to illustrate the use of adventure therapy in occupational therapy, one from adventure therapy literature and one from occupational therapy literature.

Taylor and McGruder (1996) report on the use of sea kayaking with persons with a spinal cord injury. They relate the positive physical consequences of this activity which include decreased infection, skin breakdown and weight gain. More

significantly were the psychological and spiritual benefits which enabled the clients to experience themselves as equal with non-injured people, and which resulted in increased self-esteem and self-confidence and greater life satisfaction. Sea kayaking was described as “fun”, it allowed for the development of balance of activities in people’s lives, and helped deal with the sudden surplus of unstructured time. Clients reported that it gave them a reason to “get out of bed” and that it provided opportunities for participating in a normal recreational activity, increased social contact, and assisted in the adjustment to a spinal cord injury.

Adventure activities are also used by occupational therapists with people living with a mental health illness to provide many of the psychological and spiritual benefits that people with spinal cord injury perceived. These activities provide experiential learning through active participation and reflection upon real situations. Adventure activities have a positive status in society and are therefore attractive to participants. They assist in the development of living skills and abilities such as time management, problem solving, organisation and preparation, but perhaps most importantly, adventure activities provide people with significant positive memories – “the building blocks of peoples psyches” (Roberts et al., 1997, p. 369).

Egan and DeLaat (1997) maintain that the day-to-day practice of occupational therapy, of which adventure activities could form a part, is implicitly a spiritual process. Because occupational therapists believe in the inherent value of all people, the way occupational therapy is done, why it is done, and how it is done, reflects an understanding that it is through occupation that people connect to other people, and make meaning of life. Connection with others and perceiving the meaning of life are essentially spiritual concepts (Canadian Association of Occupational Therapists, 1997).

### A spiritual perspective

Crabtree (1998) maintains that people engage in occupation to give their lives meaning. This perspective connects closely with Urbanowski & Vargo’s (1994) definition of spirituality as being the experience of meaning in everyday life. This connection between occupation and spirituality puts spirituality directly into the area of concern of occupational therapy.

In placing spirituality at the centre of the Canadian Model of Occupational Performance (1997), the Canadian Association of Occupational Therapists (1997) suggests, “individuals are concerned with the meaning of life and their purpose and place in the universe” (p. 18). By implication disability or ill health can impact negatively on a person’s spirituality in that it disrupts the experience of making meaning of life through occupational involvement.

Urbanowski & Vargo (1994) caution against implying that spirituality has a force that moves someone to do something or be someone, yet it seems that there are volitional forces or motivating concepts that are beyond affect and cognition (Helfrich, Keilhofner, & Mattingly, 1994). It is proposed that these are spiritual aspects of a person, and it is these aspects that adventure therapy addresses.

As occupational therapists we do not generally diagnose spiritual illness. This is usually considered to be the domain of theologians or philosophers. Yet if we accept that spirituality is one of the performance components, it follows that people may experience disablement of this aspect of themselves, as much as the physical, cognitive or affective performance components. If we agree that the spirit can become ill, then as occupational therapists we need to be able to define spirituality, diagnose spiritual illness or deficit and plan and carry out spiritual interventions.

It is maintained that adventure therapy brings to occupational therapy a range of activities that put people into situations that require of them novel solutions and new behaviours. These experiences change how individuals experience themselves within their lives, they also change the meaning life may have for the individual. These are spiritual changes if we accept Urbanowski & Vargo's (1994) definition of spirituality as being "the experience of meaning in everyday life". Therefore these activities can well be called "spiritual occupations".

### Prescribing spiritual occupations

A literature search in occupational and adventure therapy writing did not find any reference to specific spiritual illness and treatment, yet this paper asserts that as individuals we have a range of activities that we use when we are feeling spiritually disturbed, confused, overwhelmed or seeking an answer to the great questions about life and death. These activities may have helped calm us, given us insight into our circumstances as human beings and connected us to something bigger and more enduring than our own individual existence. For some people this connection is to an ultimate power, for some to nature, or it may be a connection to the sum of human experience and the human condition that is common to us all.

Most of us, when distressed or confused have read poetry, walked in the bush, visited an art gallery, or just sat and stared out to sea. Thibeault (1997) suggests making time each day for reflection and contemplation. Yet how many of us suggest to our clients that they do the same? If you have, you have been prescribing spiritual occupations. The art of the occupational therapist in this field, lies in enabling the development of spiritual abilities in clients by creating activities that are specifically designed to develop or strengthen that area of spirituality which is impaired or disabled.

Debate continues as to whether or not spirituality should be at the centre of the Canadian Model of Occupational Performance (Unruh et al., 2002). This paper is not concerned with where spirituality is placed in any model of personality or of occupational therapy. Rather it attests that spirituality is an aspect of all human beings, and that in occupational therapy we have few guidelines for the development of spiritual occupations other than religious observances. The present author suggests that adventure therapy gives to occupational therapy a range of activities that can be applied to the development or strengthening of the spiritual resources of a person through their active engagement in occupation.

### Conclusion

The use of adventure activities in occupational therapy is a relatively recent development. The exact date of when adventure activities were first used by occupational therapists is unclear, as there is no published literature describing the use of outdoor or adventure activities by occupational therapists in New Zealand. There is however, anecdotal evidence of a number of programmes in New Zealand in which adventure therapy is used. These are primarily in mental health services, where it is used with first episode psychosis clients, mainly young men and some young women, and in programmes that cater for long term service users, where the clients are again in the younger age bracket.

There appears to be a natural "fit" between adventure therapy and occupational therapy though there are differences in the philosophical foundations and the ways in which therapeutic needs are met. Adventure therapy provides a range of activities that can be used therapeutically by occupational therapists, not because a person may need or want to do these things as part of their everyday occupational life, but because doing so has the potential to address aspects of spiritual disability. And because doing so may enhance their self esteem and take them out of the realm of their own (often limiting) self perceptions, to a place of new confidence which can be generalised to other areas of their life.

This paper has been written because the author believes that adventure therapy has an enormous potential to be a powerful tool in occupational therapy, to bring about change in clients behaviour as well as to increase fulfilment and the meaning of life. It is maintained that this happens primarily because adventure activities are directed at the spiritual aspect of the person. This paper is limited by the paucity of the documented use of adventure activities in occupational therapy, but further research will no doubt reveal a deeper appreciation of the many ways adventure therapy impacts on the self-perception and life satisfaction of occupational therapy's clients.

### Key points

- Adventure therapy activities are becoming increasingly widely used in occupational therapy.
- Adventure activities cannot be considered activities of daily living, yet it is clear that clients benefit from participation in these activities.
- As spiritual beings, people make meaning and create identity from their involvement in occupations
- Involvement in adventure activities can restore motivation, raise self esteem, and has a positive impact on client's ability to live a more satisfying life by impacting on the spiritual aspect of a person.

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# Changing healthcare and its challenge for occupational therapy

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## Abstract

This is a historical look at the significant changes that have occurred within healthcare in New Zealand during the 1990s. Occupational therapy as a profession has had to become more adaptable and articulate to survive these reforms. In 1999 the health sector moved back to its earlier local political origins but this hasn't meant a return to the past for occupational therapy. Finally primary healthcare is identified as a future direction for occupational therapy to consider as the profession has a vital role to play in this area.

## Key words

Health reforms, primary health care, professionalism

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## Introduction

The New Zealand government, since the passing of the Social Security Act in 1938, has had a comprehensive role in providing healthcare for its population. Up until the early 1990's the structure of the New Zealand's healthcare delivery systems have remained relatively unchanged.

1993 heralded one of the most radical healthcare funding changes. These had a significant impact on health services and the health professionals that provide them. Challenges to occupational therapy were significant and this article is a historical look at these. A change of government in 1999 produced another revision to healthcare funding and the possible implications on occupational therapy are discussed.

Finally, using examples from Canada, primary healthcare is identified as an area occupational therapy should look to for the future.

## The 1990s

It had become clear by the 1990s that the organisation of New Zealand's health sector required addressing. Costs had increased in the health sector but the availability and quality of the services being provided had not. The focus of the health reforms was to ensure allocative and technical competence, with the aim of getting value for money (Bloom, 2000).

Three central themes emerged from the reforms. The purchaser/provider split, contracting for services and new public management.

## Purchaser/provider split

The purchaser/provider split rests on two economic theories, principal-agent theory and theory of competitive markets.

Principal-agent theory explains how contracts written with appropriate structure can align an agent's (provider's) incen-

tives to perform certain tasks with the preferences of the principal (purchaser) who has the responsibility of determining the task objectives. A contract that clearly defines the outputs (services) to be provided, and defines a single performance indicator for each output, makes the agent more accountable than if they have discretion over how to pursue a set of loosely defined objectives (Boston, Martin, Pallot, & Walsh, 1996).

The theory of competitive markets dictates that organisations in such a market will be forced to use resources efficiently in order to produce output at the lowest possible cost allowed by technology. This is expected to bring strong gains in efficiency and accountability (Boston et al., 1996).

The purchaser/provider split was actioned with the introduction of four Regional Health Authorities (RHAs), as the purchasers. They were required to contract for services that would maintain, improve and restore the health of their populations. The purchasing role required them to develop contracting skills as well as setting strategic directions and setting priorities (Howden-Chapman & Ashton, 1994).

## Contracts

The RHAs were required to purchase all health services including public health (that is, population-based) services through legally binding contracts. To foster competitive practices these contracts were also subject to the Commerce Act 1986 (Howden-Chapman & Ashton, 1994). The Act promotes competition in markets within New Zealand for the long-term benefits of the consumer. It applies to all individuals and businesses.

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## New public management

With the introduction of the health reforms the concept of new public management was concurrently introduced. This concept is based on the principle that differences between public and private sectors are seen as being insignificant. The public system was therefore expected to perform as a private business with an expectation of returning a profit. Outcomes were to be quantifiable, contracts were for shorter terms and tightly specified and remuneration's became performance linked (Davis & Ashton, 2001).

## The challenge for occupational therapy

Although there is no specific literature on the impact of these reforms on occupational therapy practice in New Zealand, themes can be deduced from looking at the three key influences of the health reforms, which bear a marked similarity to those that occurred in the United Kingdom (Lloyd-Smith, 1994).

## Purchaser/provider split

Prior to the 1993 health reforms occupational therapy team leaders, working within a publicly funded hospital system, were able to relatively autonomously establish new services based on recognised need. After the purchaser and provider split all public funded services had to be negotiated and purchased by the RHAs, this meant there was no longer room for meeting changing needs or professional interests, that occurred outside of these negotiations.

The splitting of the purchaser and provider opened up the possibility private and voluntary organisations also providing services with a subsequent increase in job options in the private sector.

## Contracts

Working in a more competitive environment, it now became imperative for occupational therapists to skilfully articulate their roles and functions in order to justify funding, not only to the purchaser but also to managers wishing to contract for multidisciplinary services.

With public and private providers competing for contracts, a door was opened for occupational therapists to compete for contracts themselves. Occupational therapists with high levels of expertise in specific areas, for example driving assessments, could resign from the public system and contract to independently provide the service. United Kingdom studies have shown that occupational therapists who could negotiate a clearly defined area of expertise, found it easier to survive the reforms (Lloyd-Smith, 1994).

## New public management

Occupational therapy managers were required to integrate clinical and administrative/financial functions with their performance being measured in terms of achieving cost effective clinical outcomes. In order for occupational therapy managers to run their departments as businesses they had to shift their solely clinical focus to a more comprehensive management role. This required

the development of skills such as strategic planning, contracting, zero budgeting, performance management and the development of key performance indicators for both individual and service wide performance (Kendall, 1994). If they didn't, then they ran the risk of being managed by non-occupational therapists and the profession and its service being significantly compromised as a result. The introduction of managerialism therefore provided the impetus for some occupational therapists to further their knowledge and skill base and move into roles they previously didn't occupy however for others ethical dilemmas arose between budget restraints verses the provision of a quality occupational therapy service (Kendall, 1994).

In the mid 1990s the reforms were refined as a result of increased public dissatisfaction, as the promises of improved healthcare and responsiveness didn't come to fruition. The basic principle of the purchaser/provider split and contracting for services remained.

## Current healthcare provision

With the change of government in 1999, there was a decision to decentralise healthcare by moving it back towards its earlier local political origins. The government merged the functions of the purchaser into the Ministry of Health and established greater community input through representation on the twenty one district health boards (DHBs).

The DHBs are predominantly locally elected with a minority ministerially appointed who are accountable to the Minister of Health. A minimum of two of the members on the board must be Māori. The boards are responsible for most health and disability support services, including the level, mix and quality of services and meeting the health goals, targets and standards set by the Minister of Health. They also own and run the public hospitals. Allocation of funding to the district health boards is based on the resident population weighted for relative health needs. These structural changes represent a radical departure from the system that was in place during the 1990s, with the elimination of the purchaser/provider split (Devlin, Maynard, & Mays, 2001).

The perceived benefits or criticisms of the changes are still being debated, and it will take time before the impact on occupational therapy is clear. Two possible criticisms are briefly outlined.

With the purchaser (DHBs) also competing to provide a number of the services for their population, potential conflict of interests arise. Occupational therapists working within smaller providers competing against the dominant purchaser for contracts stand the chance of no longer providing services through the publicly funded system.

Local groups with financial lobbying power would prove difficult to compete against. Small or non-traditional occupational therapy practices would need to align themselves with multidisciplinary teams with lobbying power to access contracts.

## Looking forward to the future

As societies' resources dwindle, the promotion and maintenance of health in the future is dependent upon shifting resources

away from traditional illness based models of health delivery and towards a community focused health and wellness model (Manitoba Society of Occupational Therapists, 1995).

Primary health is a holistic, community-driven model of health care, which emphasises health promotion. It is not simply the delivery of traditional health services rather it looks beyond them, it incorporates all sectors that affects a person's health. These may include and are not limited to, housing, sanitation, transport, nutrition, budgeting, employment and education (Manitoba Society of Occupational Therapists, 1995).

Occupational therapists have the unique understanding that illness and disability do not occur in isolation, but rather in the context of a person's family or community. Therefore they have a critical role to play in primary health care, working with a client to identify conditions that limit performance of occupations, supporting healthy lifestyles, to prevent illness and disability and promote health. Primary health care and occupational therapy have a common, philosophical base that supports a holistic approach to health (OTWorks, 2002).

Currently Primary Health Organisations (PHOs) are being established in New Zealand. They are to provide primary health care services, which are directed towards improving and maintaining the health of their population as well as restoring health when unwell (Ministry of Health, 2001). Occupational therapists in New Zealand have not traditionally worked in primary health services, though it would appear they do have a valuable role to play and would contribute greatly to the PHOs achieving their goals. Possible ways occupational therapists could become involved would be, forming links with General Practitioners, combining with community groups to provide well elder house checks, and vocational habitation and rehabilitation with targeted health groups.

If occupational therapists are to work in the primary health services then the professions leaders and advisors have a vital role to play in the articulation of the unique role of occupational therapists in many sectors, not only the traditional health sector. They must continue to facilitate community action in the planning, development, implementation and evaluation process of primary health care (OTWorks, 2002).

As the focus of healthcare funding changes, so to must occupational therapists diversify in their areas of practice so as to ensure the profession survives.

## Conclusion

The New Zealand government, since the passing of the Social Security Act in 1938, has had a significant role to play in funding and providing a public health system that is available to all New Zealanders. The reforms in the early 1990s were a move towards a market-orientated structure for health. The three major themes that emerged were the purchaser/provider split, contracts for services and new management plan.

The challenges for occupational therapy were significant. With the expectation that occupational therapists practice become accountable to budgeting has placed many in a precarious ethical dilemma of their clinical practice verses financial accountability.

For others it was an opportunity to diversify and to abandon the public sector and move into private business.

If as a profession it is to survive then it must embrace the challenges. With today's focus heading towards providing primary health care services occupational therapists must align themselves with providers of these services, such as general practitioners, community groups or as providers within the primary health organisations. The professional body, leaders and advisors have an important role to play to ensure this happens. They are required to articulate the unique role occupational therapists play and to promote the common philosophical base occupational therapy and primary healthcare share.

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# Tools for Practice in Occupational Therapy

Rosemary Hagedorn. 2000. London; Harcourt Publishers Limited. 326pp. Paperback.

Reviewer: Kylee Henriksen, BOT, Gisborne Hospital, Gisborne, New Zealand.

This book attempts to convey some of the fundamental skills and arts of practice while making connections between these and the principles that underpin their use. The book has a number of aims including telling you what to do and how to do it and aiming to re-establish the links between knowing and doing – between the simplicity of the therapists actions and the complexity of the clinical reasoning. It is mainly aimed at students, but is useful to any occupational therapist to link theory and practice. It is based on the writer's own personal experience using her own model of practice.

The writer uses her own model called the Competent Occupational Performance in the Environment (COPE). It is a person-centered (individual is a partner in the therapy), process-driven (the therapist selects an approach once goals have been set with the client), occupational performance model, which has a hierarchy of occupational levels. Organisational is the first level, which is based on roles and occupations, which organise and unify performances over one or more years. The next level is the effective level which is based on routines and habits which organise performance over weeks or days, and the final level, the developmental level is based on tasks or behaviours which last for three to five minutes. Dysfunction can occur at any one of these levels. The model includes a number of assumptions including the person, occupation, environment, therapist, (POET) triangle, in which balance needs to be restored (following any sort of accident or decline in function). The triangle helps to choose an applied frame of reference eg. if someone has a decrease in range of movement the biomechanical model may be used, or if someone has a decrease in an ability to perceive and process information the cognitive-perceptual model may be used. Emphasis of the COPE model is to restore the 'balance' between the abilities of the person, the demands of the task and the demands of the environment. The therapist intervenes to restore or create a 'fit' between these elements. The model also incorporates a process of change – development, adaptation, rehabilitation and

education (DARE), as well as some core processes including, therapeutic use of self, assessment and evaluation of the individual, potential abilities and needs, analysis and adaptation of occupations, and analysis and adaptation of the environment. The hierarchical environmental levels include proximity to, accessibility by the user, and the significance of the context to the user.

Using the COPE model, the writer then looks at the process of using this with a client incorporating the following five stages. Stage one is profiling, for example, getting past, present, and future information of the clients roles and occupations. Stage two is naming the problem, for example, working with the client to work out where and what the problems are in achieving these occupations. Stage three is the diagnosis – framing the problem stage, where the situation is defined within the COPE model and according to any frame of reference used eg. biomechanical. Stage four looks at prioritising the interventions and stage five is the action plan/goal setting stage.

The writer then goes into depth about therapeutic use of self, and how it is arguably the most important core process of occupational therapy. She discusses this in much detail looking at the personal characteristics, which promote therapeutic use of self, the therapeutic relationship, and interviewing and teaching skills.

The last few chapters look at assessment, why we assess, when to assess, who to assess and which assessments to use, giving examples of which assessments to use when assessing at the developmental, effective and organisational levels. Also occupational analysis and adaptation, why do we analyse occupations, how to analyse these and what to analyse, and how to help your client adapt to new ways of doing things. Lastly environmental analysis and adaptation including types of adaptations that can be done to the environment to promote movement and challenge process skills, home visits and health and safety aspects to be aware of.

This book is easy to read and understand giving you a clear process to follow looking at client dysfunction, assessment and intervention and the aspects that are needed in each of these phases. It describes a new model to use in practice that allows the most suitable frame of reference to an individual client. It is useful to read for any therapist to reinforce or get a better understanding of the aspects needed in occupational therapy practice.

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