ADL Evaluations in Long-Term Care Facilities

In the August 1994 issue of AJOT, authors Arwood, Holm, and James ("Activities of Daily Living Capabilities and Values of Long-Term Care Facility Residents," pp. 710–716) concluded that residents of long-term care facilities tended to report greater ability in activities of daily living (ADL) than did staff members.

In my many years as an occupational therapist, I have also found this to be true. Perhaps these residents viewed their abilities in ADL as temporary, after all, in their 80-something years of living, their dependence in ADL may be recent, such as the result of a fractured hip that happened only last month. And they may continue to see themselves as state that they are independent in their ADL abilities. Thus, when asking residents to describe their ADL status, I specify the time frame. For example, instead of asking “Do you need help with bathing?” I might ask “Did you bathe yourself this morning?” “Did you need some help with bathing this morning?” or “What did you need help with this morning while bathing?” This helps reveal to both of us the true current ADL abilities.

I hope this small revelation of mine can be useful to other occupational therapists doing ADL evaluations in long-term care facilities.

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Attempts to Study Ross’s Five-Stage Group Program Are Welcome

I am writing to comment on the research study, “Efficacy of a Sensory Integration Program on Behaviors of Inpatients With Dementia,” by L. Robichaud, R. Hébert, and J. Desrosiers (April 1994 AJOT, pp. 355–360). This scholarly study is a noteworthy attempt to establish long-term changes or outcomes in the behavior and functioning of institutionalized patients with dementia when exposed to Ross’s Five-Stage Group structure based on sensory integrative principles.

Formulating this approach and immersing myself in it for the past 20 years have served my passionate belief that anyone who can show some facial or motor response (regardless of linguistic ability) is entitled to the healing powers of a well-conducted group. The Five-Stage Model continues to be my way of achieving short-term goals and immediate results. The intent of the structure is to provide a systematic treatment procedure to achieve the consistent outcome of alert calmness as evidenced by postures, expressions, random acts of helpfulness by group members to each other, willingness to come, to try an activity, and to linger as if wanting more at the session’s end, by members of populations who may be often ignored as individuals. I expect that a group member will not have an undesirable outburst after the session on that day. Thus the Five-Stage Model has an effect for a certain amount of time and then another treatment or fix is required, as an occupational therapist from Australia once humorously observed for me. The second edition of my work on integrative group therapy further describes this. The authors, I note, used the first edition.

As the authors observed, many clinicians use the Ross approach. Substantive results of long-term outcomes of the approach should be documented and are not. One study I received from a master’s student indicated that holding a group session before meal time with regressed elderly patients resulted in their displaying better eating behaviors for the meal and these were delineated. It would be helpful to establish for any group member the extent to which disruptive behavior was reduced on the day of the group session or to know whether two or three sessions a week are required for longer lasting results. I was glad to see this article and am grateful to the authors for their serious work. I hope this study will stimulate the implementation of other studies examining my approach.

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