Bringing a Top–Down Approach to Pediatrics

In “Occupation-Centered Assessment of Children” (AJOT, May 1998, pp. 337–344), Coster presented an adaptation of Tromby’s (1993) occupation-centered assessment, which is implemented primarily with adults, because she believes that this type of assessment is also needed for the pediatric population. This assessment, which uses a top–down process where the therapist begins by gathering information about what the person’s wants or needs to do to fulfill his or her roles, has several benefits. It sends a message to parents, teachers, and other team members about the full scope and depth of occupational therapy practice. When the evaluating therapist begins to interview persons about a child, the range and focus of questions will communicate our full area of concern. The message will be that occupational therapy practice is not limited to components, such as fine motor abilities or sensory processing, but encompasses broad areas, such as self-care, play, socialization, interpersonal skills, and classroom skills—in short, the whole child in all of his or her contexts. This message is a unifying force among pediatric therapists who feel limited to intervention in only one setting. It also unifies pediatric therapists and practitioners of other populations. When all occupational therapy practitioners focus on the roles, contexts, and priorities of the client, we will have a profession that offers a unique method of intervention.

Some pediatric therapists consider the whole child during the evaluation process. However, Coster’s call for formalization of this thinking through functional tools and documentation is beneficial. When a therapist neglects to share his or her line of clinical reasoning with others, it may appear that component skills are the therapists’ primary concern. Having tools and documentation standards that reflect a more complete reasoning process will help to demonstrate occupational therapy’s domains of interest. Another benefit of using an occupation-centered assessment is that it enhances the writing of individualized education plan goals, which is a source of concern for many school-based therapists. Goals can be more clearly linked to the requirements of the curriculum and the demands of the environment with the top–down approach than with a bottom–up approach. Outcomes are easier to measure, and educators see how our intervention attempts to assist the child’s performance in the classroom.

The fact that few standardized assessments that use a top–down evaluation are available limits pediatric practice. Because new tools take a considerable amount of time to develop, pediatric therapists may need to develop nonstandardized tools and checklists that move the clinical reasoning process from the bottom–up approach toward the top–down approach. One example might be a checklist that outlines the various roles in which a child might engage. Sharing these nonstandardized tools and checklists with other pediatric therapists at various state and national conferences might be a way to promote “occupational” thinking. Meanwhile, efforts to develop standardized top–down assessments for an array of pediatric age groups and settings should be encouraged. Many school settings want standardized scores to determine eligibility for related services and to measure progress of intervention efforts.

Whether doing an occupation-centered assessment is more costly than doing a component-driven assessment could be addressed by comparing the time needed to complete each one. If pediatric therapists and their employers can be assured that the time allocated for evaluations and intervention would not increase, more therapists might use the top–down versus bottom–up approach.

School administrator and parent satisfaction with these two types of approaches could also be compared. These groups are generally considered to be the consumers of occupational therapy services. Their degree of satisfaction with top–down assessments would influence the use of this assessment approach.

Research may be able to provide us with better methods for interviewing and observing young children to elicit information about their priorities, which is inherent in a top–down approach. Currently, pediatric practice focuses on the family’s and school’s priorities rather than on the child’s priorities. Perhaps the priorities of all three parties (child, family, school) should be considered in order to provide the best possible intervention.

Coster’s call to implement an occupation-centered model into pediatric practice is important not only because it will assist in unifying our practice, but also because it more clearly explains the services of our profession to others. Adhering to a model of practice applicable to all populations and settings will help us to articulate in one voice what we do. Coster’s and Tromby’s ideas and the research that will surely follow can only enhance pediatric occupational therapy and the profession as a whole.

Deborah Marr, MS, OTR/L
Rome, New York

Reference

Take Action on Efficacy Studies
I have been an occupational therapist for 3 years; I have been active as an AOTA member, state member, and regional member; and I have attempted to stay current with the literature. In the past year, I have been disappointed by the negativity of articles in AJOT regarding the lack of efficacy studies in occupational therapy and the fact that all members need to be responsible. I believe that all members need to be responsible, but I also believe that occupational therapy students are not getting the education they need to create efficacy studies in occupational therapy. The AOTA, colleges, and universities need to lead the way in research, emphasizing practice areas in which occupational therapists are working, education of students on research in clinical and community settings, and the creation of networks throughout the country where universities assist in the development of studies by staff occupational therapists. If I were in Sharon Gutman’s position (AJOT, September 1998, 684–689), I would be putting my energy
into literature reviews of multidisciplinary efficacy studies, studying and promoting the role of occupational therapy in our largest populations served (i.e., stroke, head injury), and contacting hospitals and community settings around me to see how I can help them set up efficacy studies.

I am tired of hearing about other disciplines using activities of daily living (ADL) and instrumental ADL. We should be proud to be the main service provider of these areas and take credit for moving other disciplines in this direction. It is time to be positive about occupational therapy and what we do; it is time to publish efficacy studies on how occupational therapists improve client function (not grip strength and required forces in accessing everyday containers in a normal population [AJOT, September 1998, 621–626]). I have seen very few articles published in AJOT that directly relate to occupational therapy improving client function. It's time to take action.

Richard Pankiewicz, MS, OTR/L
Springfield, Missouri

Author’s Response
I agree with Mr. Pankiewicz that schools need to be involved in training students to perform research. As members of the profession have become more aware of the need to produce efficacy studies, many schools have responded by revising curricula to include research education. The push to train entry-level students to gain greater proficiency in research skills has been mandated by AOTA and AOTF—two professional bodies that have readily supported outcomes research.

I disagree that occupational therapy is perceived by other professionals as the “main service provider of these [ADL] areas.” I also disagree that the profession can assume “credit for moving other disciplines in this [ADL] direction.” Managed care organizations, the World Health Organization, and the Pew Commission are the bodies most apparently responsible for the impetus among all health care professions to provide services that address functional ADL. Lastly, although critiquing an author’s work is a professional activity that can lead to a diversity of new ideas ultimately benefiting the profession, Mr. Pankiewicz’s assumptions that I do not participate in “multidisciplinary efficacy studies, studying and promoting the role of occupational therapy in our largest populations served (i.e., stroke, head injury), and contacting hospitals and community settings around me to see how I can help them set up efficacy studies” are unfounded.

Sharon A. Gutman, PhD, OTR
Long Island, New York

The American Journal of Occupational Therapy welcomes letters to the editor. If you have a comment about or reaction to something that has appeared in the journal or about an issue that affects us or the profession, let us know your views. Type the letter double spaced and forward it to Betty R. Hueskeus, Editor.

CORRECTIONS

To “Occupational Therapy and Hospice (Statement)” (November/December 1998, Volume 52[10], p. 872):
The citation for the opening quotation was left off. The text should read: “Within every person is a distinct and unique being that is unlike any life that as existed or will ever exist again.” Clark E. Moustakas, 1977, p. 1.”

To “In Memoriam” (November/December 1998, Volume 52[10], p. 921):
Nancy Griffin of Denton, Texas, is, in fact, alive and well. She had written to inform AOTA that E. Catherine Currie of Grandbury, Texas, is deceased.

The AJOT editorial staff regrets these errors and hopes that readers were not inconvenienced.