Independence Through Activity: The Practice of Occupational Therapy (Pediatrics)

(transformation, change, clinician)

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This article discusses the impact of pediatric theory development upon the techniques used in the delivery of occupational therapy service and the reciprocal effects of pediatric practice upon further theory development.

Types of change are discussed and applied to occupational therapy practice approaches.

The practice of occupational therapy contributes uniquely to the scope of our profession in that it addresses, in an ongoing and dynamic manner, the needs of the persons for whom our expertise evolved—our patients, our clients, our consumers. Accountability to our consumers has brought to light the self-actualization of the practice of our profession. We have come to understand that we are not as interested in destinations as we are in the demands of the journey. For it is in the journey, or the process of occupational therapy treatment, that we engage patients in purposeful activity. We endeavor to provide a therapeutic situation that will contain enough challenge to allow patients an opportunity to adapt to their environment without the stress that increases dysfunction. Locating this fine line is what I consider to be the art of therapy.

Pediatric occupational therapy

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has been challenging in recent years. As pediatric therapists we have long based our focus upon developmental theorists, such as Piaget (1) and Gesell (2). From our common philosophical base, that purposeful activity can enhance the process of adaptation, several pediatric occupational therapy clinicians have questioned the level of effectiveness obtained through the therapeutic approaches then current. To address these questions, clinicians have had to accept the prospect of change.

Marilyn Ferguson, Editor of the Brain-Mind Bulletin and author of the Aquarian Conspiracy, described four levels of change that seem to demonstrate the effects that practice has upon the development of new theories and the reciprocal effect of those theories and philosophical base upon practice (3).

The first is called change by exception. At this level, we cling to old belief systems, and determine that new information is an anomaly, an isolated situation that does not fit the rules. This type of change says "I'm right, except for..." We often find ourselves in this situation early in our practice careers. The basic sets of principles learned in school form the base upon which we must build our practice approaches. When we then confront a child who does not follow the developmental sequence the way we understand it, it is easy to label the child an anomaly, rather than consider that our knowledge framework needs refinement or revision.

Change by exception only lasts for a time in the practice setting before the number of exceptions becomes incongruous. We begin to change only those parts of our belief system that must be changed in order to accommodate current observations. This is called increment change. If we see several children behaving in a way identical to or similar to that we had previously identified as an anomaly, then we can no longer call this behavior an exception to our beliefs. We must adjust the belief slightly to fit this small group of behaviors into our belief system. Increment change says "I was almost right, but now I am right." Increment change is an unconscious effort to maintain equilibrium. At this level of change we are not yet ready to give up the certainty of our knowledge and understanding.

Eventually, new information conflicts with old beliefs; then we abandon our old beliefs and rally behind new ones. This is called pendulum change. This change usually occurs at the exclusion of the rich and valuable parts of our old beliefs. We say "I was wrong before, but now I am right." So many exceptions have invaded our reality we cannot cope with them all. To regain a temporary state of equilibrium, we choose; we think that choosing new information to replace the old is better, and more progressive. We repress any incongruities, and feel we have reached a higher level of knowledge, when, in fact, we have only traded one group of beliefs for another. Unfortunately, many times we stop with this new choice, which places us at the first level again—change by exception, and we will struggle with incongruities in the same manner again and again.

The only exit from this unproductive cycle, then, is through paradigm change, a concept first developed by Kuhn, and used by Ferguson in The Aquarian Conspiracy (3). This is the new perspective, the insight that allows information from all sources to come together in a new form or structure. It is at this point, and at this point only, that we integrate and refine; we rise above the either-or choice of previous levels of change. Paradigm change says "I was partially right before, but now I am more partially right." Rather than new information being threatening to our equilibrium, it offers the opportunity to enlarge and enrich our knowledge base. There is new, interesting territory to explore and discover. Our knowledge becomes broader and more enlightened with each new discovery.

Each of us experiences these four levels of change as maturity is reached in careers and in life. Our profession, too, has collectively experienced these levels of change. In pediatrics, these changes are reflected in our approach to practice issues. Formerly, the developmental sequence primarily determined what was to occur during treatment. Those children who did not improve as expected with this approach were exceptions, and were dealt with case by case. Some intuitive clinicians saw more than the developmental sequence and the transformation began. These clinicians searched for answers to the questions that arose in their practices. Why don't certain children respond to the techniques I am using? How does the dysfunction I see affect the developmental sequence and the child's pursuit of play as his or her occupation? What is happening with the nervous system and how does what I observe relate to those internal occurrences? How must I adapt the environment to enhance the developmental process? What are the effects of my intervention upon later adaptability? As Ferguson stated,
“visionaries” who seem to have detected the coming change from early, sketchy information. Logic alone is a poor prophet. Intuition is necessary to complete the picture. (3, p. 88)

These visionary clinicians dared to use their intuition to ask difficult questions. Our present pediatriic theories have evolved from this, including the Bobath’s Neurodevelopmental Treatment, and A. Jean Aytes’ Sensory Integration.

In discussing the development of theories, Ferguson expanded upon thoughts of Einstein, to state:

Creating a new theory is not like erecting a skyscraper in the place of an old barn. It is rather like climbing a mountain, gaining new and wider views, discovering unexpected connections between our starting point and its rich environment. But the point from which we started out still exists, and can be seen, although it appears smaller and forms a tiny part of our broad view . . . .” (3, p. 150)

These clinicians and others did not abandon the important contributions of the developmental approaches, but they attempted to identify additional factors that would improve or diminish the child’s ability to adapt and respond as the child progressed developmentally.

Now an even greater paradigm change is occurring in pediatric practice. Other clinicians’ contributions have broadened the perspectives about how the nervous system, the developmental process, the child, and the environment interact to maximize positive outcomes. Many of our successful constructs are being combined into new organizational structures.

Randolph and Heineger (4) have reorganized many of the theories of our therapy practices into a structure they call The Learning Tree. Their framework enables us to see the relationships between theoretical constructs and how they complement each other. Grady and Gilfoyle (5), in their theoretical framework called Temporospatial Adaptation, artfully combine ideas from many sources to determine that the entire adaptive process spirals around itself as the child becomes increasingly more competent. More recently, Knickerbocker (6) developed a holistic approach to treatment in which she organizes clinical constructs into program plans that address the whole child, and that help that child to become more adaptive in all life tasks. These are a few of the many persons involved in paradigm changes in our profession. The exciting part is that occupational therapy, as young as it is, has moved beyond increment and pendulum change into open-minded transformation.

The practice of occupational therapy, being dynamic, provides an ongoing arena in which we are challenged to learn more and more. As soon as we become slightly assured that we have found the “truth” and begin relying upon new-found ideas to guide our therapeutic process, a unique person or situation presents itself to remind us that the journey is our task, the journey itself is our destination. Clinicians must never end their journey by settling for increment or pendulum change; this provides false security and is a short-lived steady state. We must cherish the attitude that what appears confusing and incongruent at face value is an invitation to explore new territory. These invitations offer the opportunity to broaden our knowledge base and should never be misinterpreted as a threat to our present state of knowledge. “Paradoxically, if we give up the need for certainty in terms of control and fixed answers, we are compensated by a different kind of certainty—a direction, not a fact. We begin to trust intuition, whole-brain knowing . . . .” (3, p. 107)

As we accept more and more of these invitations, this constant and necessary unrest will have its affect upon theory development as attempts are made to reorganize an ever-increasing body of knowledge. Once a single mind has discovered the truth, those ideas will eventually impose themselves upon all of human consciousness (3). The only thing that remains stable throughout this evolution of change is our philosophical base. Occupational therapists are dedicated now, and will always be dedicated, to the prospect of engaging clients in purposeful activity, increasing levels of competence in various life situations. Isn’t it wonderful to consider that our purpose will always be the same, no matter how we have to adjust our knowledge to be more effective at doing that very thing? Changes in functional performance may engage different information, but our therapeutic purpose will remain constant throughout our journey.

REFERENCES