LEARNING OBJECTIVES

After studying this chapter, the reader will be able to do the following:

1. Describe the components of personal, social, and cultural context that influence occupational therapy assessment and guide treatment planning.
2. Employ methods for quantifying the influence of various contextual factors on performance.
3. Recognize the role of contextual factors in the development of conditional reasoning in clinical practice.
4. Examine his or her own contextual fabric—the personal, social, and cultural factors that shape the therapist’s everyday experiences.

Assessing Context: Personal, Social, and Cultural

Mary Vining Radomski
Much as a phrase, punch line, or couplet can be understood only in the larger context of a story, joke, or poem, a client’s performance during occupational therapy assessment can be interpreted only in light of the broader context of his or her life and background. For example, lack of eye contact during an initial interview can easily be misinterpreted as lack of interest or motivation unless the therapist appreciates the contribution of cultural background—that avoiding eye contact is a way of showing respect in some cultures, including the Vietnamese culture (Farrales, 1996). Difficulty selecting clothing during a dressing assessment may be erroneously attributed to a patient’s poor decision-making skills unless the therapist appreciates the contribution of social role experiences—that for 50 years, the patient’s wife set out his clothing each morning.

The term context refers to the whole situation, background, or environment that is relevant to a particular event or personality; it has its roots in the Latin word contextere, to weave together (Webster’s New World Dictionary, 1994). Occupational therapists appreciate that a person’s function at any moment is shaped by a tapestry of contextual factors, and not solely by his or her capacities, acquired skills, and abilities. Without deliberate attention to these personal, social, cultural, and physical mediators of performance, therapists may misunderstand what they observe during assessment and risk assigning erroneous labels of dysfunction.

This chapter describes the personal, social, and cultural contextual factors that help or hinder performance during occupational therapy assessment. (Chapter 11 focuses on assessing contextual factors associated with the built or physical environment.) After summarizing the role of context in human functioning, this chapter discusses specific examples of personal, social, and cultural context in terms of their potential for influencing occupational therapy assessment and intervention. Using these examples, readers are encouraged to reflect on other contextual factors not discussed herein. The role of context in occupational function cannot be exhaustively explored in one chapter; whole texts and careers have been devoted to each of these complex constructs. This overview, however, has one superordinate aim: to inspire therapists to try to interpret clients’ performance in the broader context of their background, changing circumstances, and envisioned futures.

**Glossary**

**Context**—The whole situation, background, or environment that is relevant to a particular event or personality (Webster’s New World Dictionary, 1994).

**Culture**—The norms, values, and behavior patterns that serve as guidelines for people’s interactions with others and their environments (Krefting, 1991).

**Cultural context**—Stable and dynamic norms, values, and behaviors associated with the community or societal environments in which occupational functioning occurs.

**Ethnicity**—Membership by virtue solely of one’s birth in a racial, religious, national, or linguistic group (McGruder, 1998). In and of itself, ethnicity does not predict cultural identity.

**Personal context**—A person’s internal environment, derived from stable and dynamic factors such as sex, age, mood, and cultural identity.

**Social context**—The social environment consisting of stable and dynamic factors such as premorbid roles, social network, and support resources.

**Social network**—An interactive web of people who provide each other with helpfulness and protection. Social networks typically vary in terms of reciprocity, complexity, intensity, and density (Heaney & Israel, 1997).

**Social support**—The aid and assistance (emotional, instrumental, information, and appraisal) exchanged through a social network (Heaney & Israel, 1997).

**Spirituality**—Beliefs and practices that give a person transcendent meaning in life (Puchalski, 1996).

**Occupational function** is always embedded in context, with physical, cultural, social, and personal factors shaping its form (Nelson, 1988). Figure 10-1 depicts the interweaving of personal, social, cultural, and physical context that creates the parameters of a given occupational experience. Consider how minor changes in any dimension change the tapestry: a middle-aged homemaker preparing eggs and toast for her children before they leave for school versus a middle-aged homemaker preparing the same breakfast as part of an occupational therapy assessment. The important role of context in occupational function is described by a number of models and frameworks from occupational therapy, rehabilitation, and health fields. Each of the models or frameworks summarized in Table 10-1 emphasizes the dynamic relationship between a person; his or her cultural, social, and physical contexts; and the continuum of function to disability relative to chosen roles and tasks.
The aforementioned models universally downplay the contribution of physical impairments and elevate the role of context in the explanation of human functioning and disablement but use slightly different terminology. In this chapter, contextual factors are presumed to be peripheral or unrelated to clients’ primary diagnoses or disabling conditions (World Health Organization, 2001) but central to the broad realms within which people carry out their lives.

- **Personal context** reflects an individual’s internal environment derived from his or her gender, values, beliefs, cultural background, or state of mind.
- **Social context** refers to factors in the human environment (roles, resources, and structure) that enable or deter the person’s occupational function.
- **Cultural context** has to do with the norms, values, and behaviors related to the community or society in which the occupational function occurs.

The convenience of describing personal, social, and cultural contextual factors as separate and distinct entities

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### Table 10-1. Selected Models or Frameworks that Specifically Include Context as an Element in Human Function

<table>
<thead>
<tr>
<th>Models and Frameworks</th>
<th>Synopsis of Role of Context in Occupation and/or Human Function</th>
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<tbody>
<tr>
<td>Ecology of Human Performance (Dunn, Brown, &amp; McGuigan, 1994)</td>
<td>The interaction between a person and the environment affects his or her behavior and performance. Human performance can be understood only through the &quot;lens&quot; of context, which includes temporal (age, development, health status), physical, cultural, and social features that operate external to a person. In essence, the inter-relationship between person and context determines which tasks fall within the individual's performance range.</td>
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<tr>
<td>Person-Environment-Occupation Model of Occupational Performance (Law et al., 1996)</td>
<td>Occupational function is the result of the transactive relationship “between people, their occupations, and the environments in which they live, work, and play” (p. 9). This model emphasizes the interdependence of person and environment (defined as those contexts and situations which occur outside the individual such as cultural, socioeconomic, institutional, and social considerations). It also recognizes the temporal or changing nature of person, environment, occupation characteristics, and their inter-relationships.</td>
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<tr>
<td>Occupational Therapy Intervention Process Model (Fisher, 1998)</td>
<td>Occupational performance occurs as a “transaction between the person and the environment as he or she enacts a task” (p. 514). Therapists must be aware of the client’s performance context (comprised of temporal, environmental, cultural, societal, social, role, motivational, capacity, and task dimensions) to understand, evaluate, and interpret a person’s occupational performance.</td>
</tr>
<tr>
<td>International Classification of Functioning, Disability, and Health (World Health Organization, 2001)</td>
<td>“A person’s functioning and disability are conceived as a dynamic interaction between health conditions and contextual factors” (p. 10). Contextual factors include personal and environmental factors. Personal factors are internal influences of functioning that are not part of a health condition or functional state such as gender, age, social background, fitness, lifestyle, and habits. Environmental factors, external influences on functioning, include features of the physical, social, and attitudinal world.</td>
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<tr>
<td>Occupational Therapy Practice Framework (American Occupational Therapy Association, 2002)</td>
<td>The overarching outcome of occupational therapy is to advance clients' engagement in occupation to support life participation in the context of their unique situations. As such, &quot;context&quot; (cultural, physical, social, personal, spiritual, temporal, virtual) is included in the domain of occupational therapy. Context is viewed as affecting occupational performance as well as an underlying influence on the process of service delivery.</td>
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belies their complexity, inter-relatedness, and interactive in-
fluences (Fig. 10-2). Krefting (1991) described the pervasive
influence of culture on community, families (norms, values,
and behaviors related to social context), and individuals
(such as distinctive food preferences, humor, definition of
personal space; in this chapter, considered to be a part of
personal context). Likewise, personal context may influence
social and cultural context. For example, a person’s spiri-
tual beliefs often shape his or her social network, preferred
roles, and definitions of acceptable behavior.

Personal, social, and cultural contextual factors can be
examined on a continuum of highly stable to highly dy-
namic. The relatively stable factors, such as age, gender
identity, and premorbid coping style, tend to pervade

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<th>Context</th>
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<tr>
<td><strong>Personal</strong></td>
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<td>individual’s internal</td>
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<tr>
<td>variables on</td>
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<tr>
<td>occupational function)</td>
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<tr>
<td>• Age*</td>
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<tr>
<td>• Gender identity</td>
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<td>• Values and preferences</td>
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<td>• Spirituality and meaning systems*</td>
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<tr>
<td>• Coping style (including substance use)*</td>
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<tr>
<td>• Comorbidity</td>
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<tr>
<td>• Cultural identity*</td>
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<td>• Educational background (See Procedures for Practice 10-1 for assessing literacy)*</td>
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<td>• Fatigue</td>
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<td>• Pain*</td>
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<td>• Mood*</td>
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<td>• Place in adaptation continuum</td>
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<td>occupational function)</td>
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<td>• Socioeconomic status/social class</td>
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<tr>
<td>• Social network (nature and extent)*</td>
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<tr>
<td>• Social role expectations (See Law, Chapter 3)</td>
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</tr>
<tr>
<td>• Significant others’ adjustment to disability*</td>
<td></td>
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<tr>
<td>• Norms, values, behaviors of patient-therapist social interactions*</td>
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<tr>
<td><strong>Cultural</strong></td>
<td></td>
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<td>(influence of norms,</td>
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<td>values, behaviors</td>
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<td>a particular country</td>
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<td>or community)</td>
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<tr>
<td>• Norms, values, behavior of broader community*</td>
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</table>

* These factors are discussed in this chapter.

Figure 10-2 Examples of interrelated personal, social, and cultural contextual factors.
most tasks and situations and are not easily changed in occupational therapy. For example, a patient’s educational background may affect how the therapist provides home instruction but is unlikely to be a focus of intervention (Procedures for Practice 10-1). On the other hand, the more dynamic contextual factors are transient and situational and more responsive to environment, task, and therapy than stable contextual factors. The headache that interferes with an individual’s concentration today will likely be better tomorrow. The spouse’s ability to use resources and encourage his or her loved one’s independence changes as both patient and spouse adapt to the sequelae of stroke.

Importance of Personal, Social, and Cultural Context to Assessment

Personal, social, and cultural contexts influence occupational therapy assessment and treatment in at least three ways. First, contextual factors mediate (help or hinder) performance on traditional occupational therapy assessments, skewing the results and muddying their interpretation. For example, Mr. J.’s difficulty attending to instructions during a homemaking assessment might be interpreted as solely a cognitive impairment related to his right cerebrovascular accident if the therapist did not know he was awake much of the previous night as nurses addressed his roommate’s dete-

### PROCEDURES FOR PRACTICE 10-1

#### Assessing Literacy

Occupational therapists use written materials in assessment and treatment. Clients with low literacy may try to hide their difficulties with reading, compromising the assessment and the value of written home instructions (Parikh et al., 1996). Use of a reading screen allows the clinician to identify patients who need simplified, audiotaped, or pictorial education materials.

The Rapid Estimate of Adult Literacy in Medicine (REALM) (Murphy et al., 1993) is a reading recognition test that takes 2–3 minutes to administer and score. It contains three columns of health-related words of increasing difficulty, with 66 words in all. The client is asked to start at the top of list 1 and read the words aloud until he or she completes the three lists or is unable to read additional words. He or she is allowed 5 seconds to pronounce each word. The clinician takes note of all words pronounced correctly; this number becomes the raw score that is converted to grade range estimates. Murphy et al. (1993) suggested that patients who score below the 9th-grade level need adapted education materials.

#### REALM Grade Estimate

<table>
<thead>
<tr>
<th>Raw Score</th>
<th>Estimated Grade Range and Practical Meaning</th>
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</thead>
<tbody>
<tr>
<td>0–18</td>
<td>Third grade and below. These patients may not be able to read most educational materials and probably cannot even understand simple prescription labels. Repeated oral instructions will be needed to enhance compliance; the doctor cannot simply write a prescription or give standard levels of instruction and expect compliance. Materials, including simple video and audio tapes, may be helpful if a health care worker is present during their use and is available to answer questions. Repeated oral instructions will be the key to establishing long-term compliance.</td>
</tr>
<tr>
<td>19–44</td>
<td>Fourth to sixth grade. Tremendous potential for improvement exists in this group. They should respond well to direct instruction by health care providers and should be able to read and comprehend materials written on elementary school levels. Appropriately written materials may still require one-on-one counseling for adequate understanding.</td>
</tr>
<tr>
<td>45–60</td>
<td>Seventh to eighth grade. These patients will certainly benefit from appropriately written materials, but material (both oral and written) should not be too simple (e.g., first grade) or too complex. Material written for a fourth- to sixth-grade level may be appropriate.</td>
</tr>
<tr>
<td>61–66</td>
<td>Ninth grade and above. These readers can understand much high school–level material presented to them; therefore, current educational brochures may be effective. These individuals should also be able to converse with their physicians about matters of lifestyle.</td>
</tr>
</tbody>
</table>
Assessing Context: Personal, Social, and Cultural

The therapist’s personal, social, or cultural contextual factors that obscure identification of strengths or weaknesses in occupational function

Longstanding personal, social, or cultural factors that are unlikely to change as a result of therapy

Personal, social, or cultural factors that are transient or situational; factors that may be affected by occupational therapy intervention

The therapist’s personal, social, or cultural contextual factors

Conditional Reasoning

Awareness of interwoven contextual factors is a foundation for what Mattingly and Fleming (1994) describe as conditional reasoning: viewing the client as a complex composite of premorbid characteristics and preferences, condition-specific limitations, and future potentialities. “Therapists try to understand what is meaningful to the patients, and to their perceptions of themselves and others in the physical and social contexts in which they experience their lives. To do this, therapists need an ability to imagine the clients, both as they were before the illness, and as they could be in the future. They also need to be able to enlist the patients in imagining a possible future for themselves” (Mattingly & Fleming, 1994, p. 197).

Conditional reasoning enables the therapist to appreciate the wholeness of the client and his or her situation. Although it is more often employed by experienced therapists than novices (Mattingly & Fleming, 1994), one may presume that desire to learn may expedite the acquisition of this mindset.

Looking in the Mirror: Therapist as Contextually Influenced Being

Appreciation for the influence of personal, social, and cultural context requires that therapists acquire a complex combination of knowledge, attitudes, and skills. The goal is to shift from viewing how a client can fit into the therapist’s world to examining how the therapist can understand and fit into the client’s world (St. Clair & McKenry, 1999). To accomplish this shift, therapists must acknowledge and inventory the personal, social, and cultural factors that influence their own function. As I become aware of my own beliefs and biases, social background, and culturally based expectations, I will be able to appreciate their influence on collaborations with patients and coworkers (Odawara, 2005).

In summary, clinicians need not obsess about correctly labeling or pigeonholing each and every contextual factor. Rather, therapists aim to tease out various contributions to clients’ performance during assessment so as to inform intervention planning by asking whether this person’s present performance is influenced by the following:

- Personal, social, or cultural factors that obscure identification of strengths or weaknesses in occupational function
- Longstanding personal, social, or cultural factors that are unlikely to change as a result of therapy
- Personal, social, or cultural factors that are transient or situational; factors that may be affected by occupational therapy intervention
- The therapist’s personal, social, or cultural contextual factors

Personal Context

“Life is suddenly reduced to a one dimension picture, known as ‘physical function,’ and continually referred to as ‘outcome.’ The typical outcome process ignores... emotional and interpersonal needs and skills. Within those parameters lies the answer to true recovery... I refuse to have an ‘outcome.’ I do have a life!” (Cannon, 1994, p. 3)

Personal context refers to the intrapersonal environment that shapes an individual’s experience. These factors play a role in determining the client’s unique response to the onset of illness or impairment and contribute to his or her ability to adapt (National Center for Medical Rehabilitation and Research, 1993). Some aspects of a person’s internal environment, such as age and longstanding beliefs, are stable; others, such as pain, mood, and adaptation to illness or injury (see Chapter 35), may be constantly in flux.

Personal Demographics: Age

A person’s age influences his or her occupational functioning in three primary ways: (1) age-related changes in capacities and abilities; (2) developmental shifts in goals, values, and priorities; and (3) the individual’s generation-based worldview.

Table 10-2 summarizes typical changes in capacities and abilities associated with normal aging. In tandem with physiological changes in capacities, Royeen (1995) hypothesized that people undergo “occupational shifts” (p. 11) during the life cycle that lead to major changes in patterns...
She posited that early adulthood is characterized by establishing worker roles while realigning social roles to adjust to marriage and parenthood. In middle adulthood, people maintain work and leisure roles but may undergo sudden occupational shifts related to caregiving roles of parents, children, and grandchildren. During maturity (45 years to retirement), people continue their work and leisure roles, but occupational shifts arise from death of family members, loss of provider status, and adjustments in life goals. Persons in old age must adjust to changes in role performance commensurate with deterioration of physical and mental capacities.

Finally, a person’s age location in history may influence his or her personality and beliefs (Lancaster & Stillman, 2002; Strauss & Howe, 1991). Although clinicians avoid jumping to conclusions about patients based on age, consider the ways in which generational identity may influence participation in occupational therapy for five contemporary generational groups in the United States:

- G. I. elders (born 1901–1924) strive for public harmony and cooperative social discipline and subscribe to a philosophy that optimism and hard work guarantee goal achievement.

### Table 10-2. Age-Related Changes in Physical and Cognitive Capacities and Abilities

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Physical Development</th>
<th>Cognitive Development</th>
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</table>
| 20s             | • Fully developed body shape and proportions (except weight and body mass, which fluctuate throughout a person’s life)  
• Peak muscle strength achieved  
• Fully mature reproductive systems, with both sexes experiencing involuntary cyclic alterations in sex hormone production | • Peak brain cell development (although the final number of neurons and supportive cells that a person possesses is determined by the end of the first year of life)  
• Memory capacity peaks with the brain’s greatest mass  
• Gradual shrinkage of brain cells at around age 30, but because of the vast number of unused brain cells, these changes do not impact function |
| 30s and 40s     | • Gradual slowing of body functions (dependent on diet, exercise, stress, genetic predisposition, and presence of disease)  
• Without regular exercise, gradual loss of muscle size and strength and bone mass and density  
• Decreasing elasticity in cardiorespiratory system, resulting in gradually decreasing respiratory capacity and increasing blood pressure  
• Beginnings of hearing loss (first limited to high pitches)  
• Beginnings of presbyopia (affecting near vision), which necessitates reading glasses or bifocals | • Continued gradual brain shrinkage but increasing life experiences result in high mental acumen |
| 50s and 60s     | • Physical changes of previous decades continue at a faster rate and to a greater extent  
• Fewer calories are required (necessitating changes in intake and/or activities to maintain weight)  
• Changes in amounts and patterns of hormone production affecting metabolism, energy, sexuality, and reproduction | • Continued brain shrinkage offset by reservoir of life experience, wisdom, and judgment |
| 70s and older   | • Loss of vestibular function in inner ears, resulting in decreased balance  
• Steady deterioration of vision and hearing  
• Loss of cartilage and connective tissue, leading to decreased range of motion, pain, and postural changes  
• Reduced appetite due to inactive taste buds and changes in digestion  
• Changes in metabolism, making it more difficult to adapt to changing temperatures | • Decreasing memory capacity  
• Decreasing abilities in areas of abstract reasoning and novel problem solving  
• Enriched perspectives based on lifelong learning and integrated experiences |

**Coping Strategies and Beliefs**

Premorbid coping styles and long-term spiritual beliefs and meaning systems influence peoples’ reactions to catastrophic injury and chronic illness.

**Coping Style**

The ways that people typically face stressful circumstances affect whether they seek health-related services and the extent to which they follow professionals’ advice (Lerman & Glanz, 1997). Coping styles are relatively stable characteristics of a person and are thought to mediate the effects of stress on function (Lerman & Glanz, 1997). (Procedures for Practice 10-2 describes assessment of substance use, a maladaptive coping style.)

Lerman and Glanz (1997) summarized two aspects of coping. Consider how each of them contributes to or detracts occupational therapy assessment and treatment when they are part of the client or therapist’s longstanding coping style.

- **Optimism** is the tendency to have positive rather than negative expectations for outcomes. Optimism is associated with relatively few physical symptoms during stress, and it predicts psychological adjustment. Optimists tend to use active coping strategies, such as planning, problem solving, and acceptance rather than avoidance.
- **Locus of control** is a general belief about one’s ability to control relevant life circumstances and events. People with an internal locus of control are likely to take
responsibility for change, while those with an external locus of control tend to expect other people or factors ultimately to determine a particular outcome. The assumption that one can affect one’s circumstances leads to active coping and goal-directed activity that influence outcome.

**Spirituality**

**Spirituality** refers to the beliefs and practices about the world and one’s place in it that give a person transcendent meaning in life (Egan & Swedersky, 2003; Puchalski, 1996). These beliefs may be expressed as a religious faith or directed toward nature, family, or community. It reflects a person’s overriding system of meaning that influences use of time, choice of actions, and perceptions of purpose. As such, spirituality is central to a person’s occupational function (Christiansen, 1997). In a survey of 270 registered occupational therapists in the United States, 84% of the respondents viewed spirituality as an important dimension of health and rehabilitation, but fewer than 40% of the respondents thought their patients’ spiritual needs were within their scope of practice (Engquist et al., 1997). Even therapists who believe that spirituality has a role in occupational therapy practice express concerns about their lack of experience or education in addressing clients’ spiritual concerns (Collins, Paul, & West-Frasier, 2001).

Therapists who do incorporate spirituality into their practice do so by dealing with clients’ religious concerns, encouraging patients’ core sense of self, and addressing or confronting patients’ experience of suffering (Egan & Swedersky, 2003). In a survey of 112 occupational therapists, over 63% of the respondents reported that they had occasionally or frequently discussed the fear of death and dying, meaning or purpose of illness, or faith, belief, or religion with their patients (Collins, Paul, & West-Frasier, 2001). These connections with clients become opportunities for the therapist’s development as well (Egan & Swedersky, 2003).

Riley et al. (1998) suggested that knowledge of a client’s spiritual beliefs informs treatment planning and intervention and “is clearly too important a variable to be neglected in the rehabilitation process” (p. 263). Procedures for Practice 10-3 suggests ways to discuss coping, spiritual belief, and meaning systems with patients.

**Cultural Background and Identity**

Culture is an information-based system that provides guidelines for peoples’ interactions with others and their environments (Baumeister, 2005; Krefting, 1991). Although socialization teaches these guidelines for values, beliefs, and behavior patterns, culture is emergent, dynamic, and interactional (Bonder, Martin, & Miracle, 2004). Culture is not biologically inherited or determined by geography or ethnicity (Krefting, 1991). Ethnicity is defined as “membership, conveyed by birth, in a racial, religious, national, or linguistic group” (McGruder, 1998, p. 55). It may have implications in economic, social, and political realms, but contributes little to a therapist’s appreciation of a patient’s personal context. Furthermore, clinicians are cautioned about the reliability and accuracy of ethnic designations in hospital records (Stansbury et al., 2004). Because there is as much variation within ethnic groups as between them (McGruder, 1998), a person’s ethnic background is not a reliable gauge of his or her cultural identity.

The influence of culture on a person’s experience is hard to state precisely. Although cultural rules are learned, they are also graded, flexible, task- and environment-specific, and often self-selected. For example, the degree to which immigrants have assimilated the customs and patterns of behavior of their new country or region is determined by how recently they emigrated, the primary language spoken at home, and the amount of contact with their homeland (Krefting, 1991). People adopt the culture of specific subgroups and environments; the expectations for behavior of a clinician in an occupational therapy clinic are different from expectations for a broker working at the New York Stock Exchange. The dynamic influence of culture on human experience requires that clinicians resist attempts to characterize or stereotype clients based on ethnic or geographical background. Rather, occupational therapists attempt to recognize and then step outside of their own cultural backgrounds and biases to appreciate and accept the culturally based customs, values, and beliefs of each client (Procedures for Practice 10-4).

Many occupational therapy evaluation tools are based on norms developed for a white middle-class population (Krefting, 1991; Paul, 1995). Culturally reflective clinicians assess the cultural validity of their standardized assessment tools (Krefting, 1991) and select criterion-referenced and norm-referenced tests appropriate for the person’s background (Paul, 1995). Paul described the challenges of devising culturally unbiased tests that include only items that reflect knowledge, experiences, and skills common to all cultures. He recommended the use of culture-specific evaluation tools, which include items relevant to a specific cultural group, when available. Practically speaking, it is impossible to locate culture-specific tools for all of the diverse cultural groups in North America. Therefore, therapists must make every effort to attempt to understand a client’s individual cultural background before interpreting performance on the most appropriate standardized tests.

**Pain**

Pain, acute and chronic, interferes with occupational function and quality of life for many people receiving occupational therapy services (Ehde et al., 2003). People with spinal cord injury who use manual wheelchairs report upper
Assessing Patients’ Coping, Spiritual Beliefs, and Meaning Systems

People typically share personal information with those they trust. Therefore, to explore patients’ beliefs and meaning systems, therapists invest in establishing therapeutic rapport (see Chapter 15). Without the rapport that comes with time and consistency of care providers, patients may perceive questions about their spirituality, for example, as intrusive or offensive. Therapists who are aware of their own coping strategies and belief systems will be best able to comfortably discuss these issues with their patients.

In general, discussions of these very personal and potentially sensitive matters begin at a superficial level and progress to deeper, more personal levels as dictated by the patient and therapist’s comfort with each other and the subject matter. Here are examples of this progression.

- Ask the client to provide an hour-by-hour account of a typical day prior to the injury or onset of illness (Radomski, 1995). How a person is used to spending his or her time richly defines his or her valued activities and priorities.
- Take a brief life history, asking the patient to give you an overview of his or her life course, including past goals and obstacles (Kleinman, 1988). People often use stories or narratives to make connections and meaning attributions between a series of life events (Mattingly, 1991).
- Ask the patient about his or her explanatory model of the illness or disability. Kleinman (1988) suggested that faced with illness, disability, or suffering, people attempt to construct models to explain the whys of their experiences. They make attributions about causation and outcome that are more likely to be based on personal beliefs and culture than on facts or medical information. For example, patients may feel responsible for permanent impairments because they didn’t try hard enough in rehabilitation to overcome them (Luborsky, 1997). If the person views onset of illness or disability as God’s punishment for a past sin or mistake, he or she may not feel empowered to invest in rehabilitation efforts. Only as patients’ explanatory models are acknowledged may they be negotiated with the therapist or health care team (Kleinman, 1988).
- Cox and Waller (1991, p. 86) suggested that clinicians ask patients about past experiences in which their coping skills were taxed:
  1. When you’re discouraged and feeling despondent, what keeps you going?
  2. Where have you found strength in the past?
  3. What have you done in the past when you’ve lost someone or something important?
  4. What do you think the message in this is for you?
- Puchalski and Romer (2000) recommended an acronym for aspects of a spiritual assessment (F, Faith; I, Importance and influence; C, Community; and A, Address).
  F. What things do you believe in that give meaning to your life?
  I. How have your beliefs influenced your behavior during this illness? What roles do your beliefs play in regaining your health?
  C. Are you a part of a spiritual or religious community? Is this a support to you and how?
  A. How would you like me, your health care provider, to address these issues in your health care?

extremity pain, with the most severe pain occurring while pushing the wheelchair up an incline and during sleep (Curtis et al., 1999). Dalyan, Cardenas, and Gerard (1999) found that upper extremity pain was associated with lower employment rates and greater disability for outpatients with spinal cord injury. Finally, many stroke patients have upper extremity pain as well, typically beginning 2 weeks after the onset of stroke (Chantaine et al., 1999). In addition to its contribution to disability and to decreased quality of life, pain is linked to depression (Dalyan, Cardenas, & Gerard, 1999) and inefficiencies in information processing (Luoto et al., 1999).

Pain is a highly personal experience (Dudgeon et al., 2002); an individual’s pain in the present is influenced by his or her recollections of past pain, expectations of pain, and perceptions regarding its cause (Smith, Gracely, & Safer, 1998). Many people with disabilities are used to living with pain, differentiating between usual pain and unexpected pain (Dudgeon et al., 2006). Because many recipients of occupational therapy services may be reluctant to mention their concerns about pain to therapists (Dudgeon et al., 2002), therapists take responsibility to routinely ask and/or assess.

Million et al. (1982) described two categories of pain assessment techniques: (1) those that assess the patient’s subjective experience with pain and limitations in activities and (2) those that quantify physical signs, such as moving during a physical examination and biochemical
changes during activity. Beyond observing function and behavior, the former methods seem most appropriate for occupational therapists. Two commonly used subjective measures of pain are described: the McGill Pain Questionnaire—Short Form (MPQ-SF) (Melzack, 1987) and the Visual Analog Scale (VAS) (Huskisson, 1974; Million et al., 1982).

McGill Pain Questionnaire—Short Form

The MPQ-SF, adapted from the McGill Pain Questionnaire (Melzack, 1975), is widely used to measure pain and response to pain interventions (Melzack, 1987). The tool has three components. First, patients are asked to rate descriptors from two categories that best describe the characteristics of their pain. These 15 descriptors are rated on a 0 to 3 intensity scale and then summed. The following are examples: throbbing, shooting, cramping, and sickening. The patients also complete two indices of the overall intensity of their pain (Present Pain Index and VAS).

Visual Analog Scale

The VAS is a self-administered measure of pain intensity. Patients are asked to indicate the severity of their pain by marking a point on a 10-cm line on which the end points are labeled “Pain as bad as it could be” or “No pain” (Huskisson, 1974). The rating is converted to a score by measuring the distance of the mark from the origin of the scale. Million et al. (1982) suggested that asking patients to provide one global rating of pain demands that they provide a singular estimate of their pain experience across time and situation, when in reality, pain varies with time and activity. Therefore, they developed 15 questions related to severity of pain associated with various activities, each accompanied by a VAS. Each question is answered as the patient marks the VAS based on the continuum of symptoms or limitations. The ends of each scale are described with extreme answers to the question. Here are two examples:

- Does your back pain interfere with your freedom to walk? (Complete freedom to walk—completely unable to walk)
- To what extent does your pain interfere with your work? (No interference at all—totally incapable of work) (Million et al., 1982, pp. 211-212).

Because it is brief, reliable, and valid, the VAS is often used to screen inpatients and outpatients for acute pain-related concerns, in compliance with hospital accreditation requirements (Joint Commission on Accreditation of Healthcare Organizations, 2005). The VAS will likely not provide adequate information to inform occupational therapy assessment or intervention for persons with chronic or variable pain.

Questionnaires and numerical or VAS scales should be the catalysts for, rather than replacements of, more in-depth conversations with clients about their experience with pain. A one-time rating of pain often does not represent the variability of pain that some clients experience (Zelman et al., 2004). Occupational therapists will be best equipped to interpret occupational assessment findings if they go beyond obtaining a snapshot of a client’s static pain. Conversations to explore the extent to which pain levels are manageable or tolerable will be a prelude to problem solving about the kinds of strategies that might help (Zelman et al., 2004).
Mood

Many people who receive occupational therapy services have mood disorders, such as depression and anxiety (Arruda, Stern, & Sommerville, 1999). Almost one third of geriatric rehabilitation inpatients are thought to be depressed (Cully et al., 2005). Persons with spinal cord injury, traumatic brain injury (Kreuter et al., 1998), and Parkinson’s disease (Meara, Michelmore, & Hobson, 1999) tend to be more depressed than the general population. Early identification and treatment of mood disorders is important, as depression and anxiety appear to interfere with attention and concentration during assessment (Eysenck & Keane, 1990) and negatively influence outcome of intervention (Lai et al., 2002). Although occupational therapists do not diagnose mood disorders, they have numerous opportunities to observe behavior. According to Scherer and Cushman (1997), certain patterns of behavior may indicate psychological distress and warrant referral to a psychologist or psychiatrist for further assessment and treatment.

Depression

People feeling transitory sadness and discouragement or normal grief may display signs that are similar to those of depression, but will differ in terms of persistence of symptoms and their effect on self-esteem (Gorman, Sultman, & Luna-Raines, 1989). That is, sadness and normal grief resolve with time and generally do not lead to lowered self-esteem, as suggested by the following signs of possible clinical depression (Gorman, Sultman, & Luna-Raines, 1989; Scherer & Cushman, 1997):

- Significant declines in functioning lasting 2 weeks or more
- Feelings of worthlessness, inadequacy, self-doubt
- Diminished interest in virtually all activities, even formerly enjoyable activities
- Depressed or irritable mood most of the time
- Vegetative disturbances: lethargy; insomnia or excessive sleep; change of appetite with weight change of more than 5%; periods of excessive activity or slowness almost every day
- Very poor concentration
- Withdrawal from social interaction
- Recurrent thoughts of death or suicide

Anxiety

Anxiety is different from fear. Anxiety is characterized by a diffuse feeling of dread, whereas fear is a reaction to a specific temporary external danger (Gorman, Sultman, & Luna-Raines, 1989). Here are some signs of possible anxiety disorder (Gorman, Sultman, & Luna-Raines, 1989; Scherer & Cushman, 1997) that may prompt referral to a psychiatrist or psychologist:

- Panic attack (choking feeling, nausea, dizziness, palpitations or chest pain, fear of dying or losing control)
- Distorted, unrealistic fears or perceptions of a situation or object
- Disruption of normal routines or daily activities associated with irrational fears

Despite their best intentions, occupational therapists often have difficulty recognizing these disorders. Therefore, occupational therapists are advised to use standardized screens to identify patients in need of psychological or psychiatric services (Ruchinskas, 2002). The Hospital Anxiety and Depression Scale (Zigmond & Snaith, 1983) and the Beck Depression Index-FastScreen for Medical Patients (Beck, Steer, & Brown, 2000) are good examples.

Social Context

“...it’s easy to be a good friend—exhausting but rewarding to nurse a loved one back to health. But her health never returned and chronic care takes tenacious strength when you’re also battling grief. I often feel unequal to the challenge.” (Osborne, 1998, p. 46)

Social context, including the person’s social resources, roles, and preferences, influences occupational pursuits, satisfaction, health, and well-being (Helliwell & Putnam, 2004). For example, some people select tasks and activities that put them in contact with a social network; others select occupations that allow them to avoid social interaction, as in the case of individual preferences for hobbies or careers. Social networks may facilitate an individual’s chosen occupations through emotional support, assistance, or instruction; unfortunately, some social relationships interfere with a person’s optimal function. Only if occupational therapists are aware of the social context in which occupational function occurs can they orchestrate intervention that will outlive their own involvement in a client’s recovery and adaptation.

Social Network and Support

The characteristics of a person’s social network are relatively stable social contextual factors that influence his or her identity, opportunities, and function. Langford et al.
(1997) suggested that a social network is an interactive web of people who provide each other with help and protection; that is, they give and receive social support. Social networks vary in terms of the following characteristics: reciprocity (extent to which resources and support are both given and received); intensity (extent to which social relationships offer emotional closeness); complexity (extent to which social relationships serve many functions); and density (extent to which network members know and interact with each other) (Heaney & Israel, 1997).

Social support is defined as aid and assistance exchanged through social relationships and interactions (Heaney & Israel, 1997). The four types of social support are: (1) emotional (expressions of empathy, love, trust, and caring); (2) instrumental (tangible aid and service); (3) information (including advice and suggestions); and (4) appraisal (feedback and affirmation) (Heaney & Israel).

During the assessment, occupational therapists first try to identify the composition and characteristics of the client’s social network (i.e., who these individuals are and the nature of their relationships). Occupational therapists must step outside of their own biases and expectations to appreciate that patients’ social networks take many forms, including traditional nuclear families, same-sex partners, friendships, and acquaintances. Such biases remain prevalent, insidious, and hurtful. For example, despite our profession’s stance on nondiscrimination and inclusion (American Occupational Therapy Association, 2004), Jackson (2000) described many occupational therapy clinics as noninclusive environments in which a heterosexist perspective pervades conversations, humor, and assumptions.

Second, therapists attempt to determine the types of support that individuals in the social network are willing and able to provide. For example, longstanding intimate ties typically provide emotional support and long-term assistance, while neighbors and friends most often provide short-term instrumental and informational support (Heaney & Israel, 1997). Key players in the social network assume as much or as little responsibility as they are able, and the patient–family unit becomes the primary recipient of occupational therapy services (Brown, Humphry, & Taylor, 1997). Therapists can learn a lot about patients’ social networks and resources by simply talking with them. An alternative method of assessing a patient’s social network and resources is the Norbeck Social Support Questionnaire (Norbeck, Lindsey, & Carrieri, 1981). It is a standardized, self-administered questionnaire consisting of nine items and taking about 10 minutes to complete. Patients list individuals in their personal network and specify the nature of these relationships. Patients then indicate the extent to which each person listed provides emotional, appraisal, and instrumental support.

Finally, occupational therapists appreciate that some social relationships are harmful to patients. Accredited hospitals and rehabilitation facilities are mandated to have policies in place to respond to patients considered to be vulnerable adults or potential victims of intimate partner violence (Joint Commission on Accreditation of Healthcare Organizations, 2005). Therapists must familiarize themselves with employers’ policies and procedures that describe how to report, document, and respond to cases of suspected maltreatment. For example, at Mercy and Unity Hospitals in suburban Minneapolis, physical and occupational therapists are expected to screen all outpatients for family violence (Fig. 10-3) (J. L. Miller, personal communication, February 3, 2006).

Caregiver Adaptation: A Dynamic Social Factor

Longstanding intimate ties in the patient’s social network (hereafter also referred to as family) are critical to patients’ ability to adapt to chronic illness and disability. Families influence outcome of services because they provide a context for individual change and because they represent continuity in patients’ lives (Brown, Humphry, & Taylor, 1997). The ability of significant others to provide needed support, however, is dictated in part by their own emotional and physical health and place in the adaptation process (Grant et al., 2000). Many relatives of persons with traumatic brain injury (Webster, Daisley, & King, 1999), stroke (Grant et al., 2000), and Alzheimer’s disease (Pruchno & Potashnik, 1989), for example, experience significant levels of subjective burden and mood disorders as well as role changes in work, leisure, and social life (Frosch et al., 1997). To contribute to patients’ long-term quality of life, occupational therapists assess family members’ adaptation needs on an ongoing basis.

All of the personal, social, and cultural contextual factors described in Figure 10-2 can be applied to the significant other’s occupational functioning as caregiver. That is, a spouse’s ability to learn and reinforce new techniques and strategies is affected by his or her own health concerns and distractions, age and generation, sex, mood, cultural background, makeup of the social network, and culture of the community (Murray, Manktelow, & Clifford, 2000). Furthermore, caregivers’ goals and perceptions of need from health providers change as they adapt to the patient’s illness or injury.

Corbin and Strauss (1988) described the work of adapting to chronic disability over time as “a set of tasks performed by an individual or couple, alone or in conjunction with others, to carry out a plan of action designed to manage one or more aspects of the illness” (p. 9). This work consists of not only adjustments to self-maintenance tasks and roles but also the work involved in redefining one’s identity. Corbin and Strauss used the term illness trajectory to refer to the sequence of physiological changes associated with an illness, injury, or disorder and the adaptive work demanded of a patient and family that accompanies each...
Family Violence Screening and Response Tool

What to do: RADAR mnemonic *
Routinely ask. Inquiring about family violence can be an intervention. You’re signaling that violence is inappropriate; you may be helping to end the isolation.
Affirm and support patients who acknowledge abuse.
Document objective findings; patient statements in quotes.
Address your patient’s safety.
Refer the patient to people skilled in family violence and safety planning.

When do you screen?
➤ Patient must always be alone. The exception is with infants or nonverbal toddlers.
➤ Screen all adults—both males and females.

When do you introduce the screening?
An introductory statement will lead you into asking the screening questions. This statement gives the patient the following messages:
➤ Violence in the home is a major health care issue;
➤ I care about you;
➤ All patients are asked these questions; and
➤ This is a safe place.

STATE: We are concerned about the violence that is impacting the health of many of our patients, so we routinely ask everyone the following confidential questions.

Screening Questions
➤ Have you ever been hit, kicked, pushed, or otherwise hurt or mistreated by someone important to you?
➤ Is someone important to you yelling at you, threatening you, or otherwise trying to control your life?

Response

<table>
<thead>
<tr>
<th>Affirmative response</th>
<th>Patient denies; provider concerned</th>
<th>Negative response</th>
</tr>
</thead>
</table>
| Provide affirming, supportive statements
➤ You do not deserve it.
➤ You did not cause it.
➤ I am sorry this is happening to you.
➤ There is help available to you.
➤ It is against the law to sexually or physically hurt anyone. |
| Call advocate OR offer private space and telephone so the patient can contact the local advocacy organization, when appropriate. |
| Offer educational resources explaining you have this material for community education and they might know someone who can benefit from the information. |
| Offer educational resources. |
| Document findings. |


Figure 10-3 Family Violence Screening and Response Tool. (Reprinted with permission from Allina Health System, Minneapolis, MN.)
phase. They further suggested that most trajectories have five types of phases, distinctly ordered according to various diagnoses and individual courses: acute, comeback, stable, unstable, and downward.

- **Acute phase.** The patient requires immediate medical attention and focuses on physiological stabilization and recovery. Patient and family may wonder how life will change because of the illness, injury, or disorder.

- **Comeback phase.** The patient is in the midst of physical and emotional recovery and focuses on getting physically well and regaining functional abilities. Patient and family may ask questions such as these: Will I (he or she) come back? How long will it take before I (he or she) peak? “In the comeback trajectory, the present is seen as overbearing, and the future is put on hold while one awaits answers to the foregoing questions” (Corbin & Strauss, 1988, p. 46).

- **Stable phase.** The patient undergoes very few changes in course of illness or functional abilities, as in the remission phase of multiple sclerosis or permanent spinal cord injury. Patient and family focus on maintaining stable health while wondering how long the phase will last and what can be done to extend it.

- **Unstable phase.** The patient has periodic but erratic downturns in function or exacerbations of illness (as might come, for example, with bladder infection). Unstable phases hamper normal living, and people in this phase ask questions like these: How long until we get this under control? How much longer can I (or we) go on like this?

- **Downward phase.** The patient slowly or rapidly loses health and function. With increasing incapacity, the patient and family view the present as temporary and the future as unknown. They are concerned with questions such as these: How fast and how far? When will it end? What can we do to slow it down?

Although there are no standardized methods for determining a person’s phase in an illness trajectory, sensitivity to each person’s changing path in this journey is prerequisite to creating a treatment plan that meshes with patient and family real-time needs and priorities. A family-centered approach allows the therapist to capitalize on the family’s priorities and contributions to the patient’s recovery and adaptation. This mindset, however, requires that therapists “follow the family’s lead rather than impose professional decisions” (Brown, Humphry, & Taylor, 1997, p. 598).

**Patient–Therapist Social Interactions**

Occupational therapy assessment is not a neutral process (Luborsky, 1997). Gans (1998) suggests, “Part of the way the patient behaves with you is a function of the way you are with the patient. This effect may comprise 75%, 25%, or 2% of what goes on between you and the patient, but it is there” (p. 4). Social convention and cultural norms organize the patient’s self-report of problems and symptoms and the therapist’s response to these concerns (Luborsky, 1997). The therapist is endowed with power to shape the interaction by selecting certain questions and omitting others (Luborsky, 1995), to judge or evaluate the responses of the patient, and even to determine whose expectations and “reality” are correct (Abberley, 1995).

Occupational therapists monitor the extent to which their own needs infiltrate social interactions with patients. Perhaps to meet self-imposed expectations around outcome, Abberley (1995) suggested that some occupational therapists unwittingly define the client as the problem and themselves as the solution, with failure of intervention always attributed to the patient and success always credited to the clinician’s efforts. Gans (1998) believes that a primary source of clinician gratification should stem from “the privilege of participating intimately in another person’s life” (p. 5). He further suggests that, when the work no longer feels like a privilege, one should try to figure out why (e.g., volume of caseload, private life that is distracting or burdensome, burnt out, or ethically questionable employer expectations that corrode integrity).

Clinicians also examine their expectations of their own supportive roles in patients’ lives. They recognize that professional helpers are typically not able to provide support over long periods. They realize that professional–lay relationships are not characterized by reciprocity typical of social networks and often entail invisible but palpable power differentials that interfere with the provision of genuine emotional support (Heaney & Israel, 1997). In essence, they realize that, as professionals, they should not attempt to assume a long-term role in the social network but rather work with the patient and family to create permanent social links that meet their needs.

**CULTURAL CONTEXT OF THE LARGER SOCIETY AND COMMUNITY**

“I used to dream about being in a world where being disabled was no big deal, where no one considered it a tragedy. No one thought you were inspiring or felt sorry for you…. I imagined what a relief it would be to be seen every day as perfectly ordinary.” (Tollifson, 1997, p. 105)

The dominant culture influences the ease with which a person with a disability feels accepted and integrated into the community. Luborsky (1994) suggested that culturally based requirements for status of full adult person in Europe and North America, such as self-sufficiency,
activity, and upright posture, are often at odds with full participation for persons with disabilities. Adapted equipment may be rejected because of its appearance and acceptability in public rather than its functional value (Luborsky, 1994, 1997). Patients and family may respond to embarrassment or guilt over disability by attempting to keep the disability private and denying help from friends or neighbors (Armstrong & Fitzgerald, 1996). Loss of social status is further compounded when insidious cultural beliefs hold persons with disabilities responsible for their impairments. “At a deep level there is a bias that either they are culpable for the cause of the impairment, or for not working harder at rehabilitation to be able to ‘overcome’ the odds regardless of how realistic that is” (Luborsky, 1994, p. 251). As abhorrent and illogical as such notions are, patients, families, and occupational therapists are not immune to the subtle but pervasive influences of the sociocultural context in which they live.

Occupational therapists are challenged to check many of their own assumptions about people with disabilities. For example, Kielhofner (2005) reminds us that the person-first terminology that therapists are urged to use is objectionable to some disability activists and scholars who suggest that the term “disabled person” more accurately reflects his or her true minority status. Many people resent the notion that their impairments reflect some sort of personal tragedy (Wakefield, 2005; Watson, 2002) and, instead, view their disability with pride as a part of their identity (Eddye & Robey, 2005). Even the concept of rehabilitation and remediation of impairments can be interpreted as an effort to remove a flaw or a negative characteristic, a round-about way of suggesting abnormality or imperfection (Kielhofner, 2005).

**GENERAL COMMENTS ON ASSESSING PERSONAL, SOCIAL, AND CULTURAL CONTEXT**

If nothing else, the discussion of assessing personal, social, and cultural context underscores that occupational therapists ought to not get too comfortable with their findings, scores, or impressions and learn to tolerate the ambiguity of “it just depends.” The imposing influence of contextual variables serves to keep us humble and on guard against jumping to the wrong conclusions about assessment findings and our clients.

Occupational therapists struggle to balance their preeminent concerns for service to patients with very real demands for efficiency and productivity. Clinicians typically devote 30 minutes to 3 hours assessing each patient; the short lengths of stay in acute settings allow less time; inpatient rehabilitation settings (with possibly longer stays) allow somewhat more. How does one have time to assess the web of personal, social, and cultural contextual factors on top of all pertinent areas of occupational function (roles, tasks, activities, abilities and skills, and capacities)? Here are some general guidelines:

- **Review the assessments of other professionals.** Many patients who are referred to occupational therapy are also assessed by social workers, psychologists, speech-language pathologists, physical therapists, physicians, therapeutic recreation specialists, chaplains, and/or nurses. Reviewing the assessments of team members greatly adds to the occupational therapist’s ability to understand a patient’s personal, social, and cultural context without using limited assessment time to do so.

- **Use specific tools (many discussed in this chapter) to measure contextual factors that appear to bias or confound performance during assessment or that are expected to be targets of occupational therapy intervention (to establish a baseline).**

- **Take advantage of informal conversations with patients.** Luborsky (1997) pointed out the value of attending to patients’ informal remarks made during structured assessments. He described how a patient’s comments during transitions between various standardized tools provide insights not captured by the tools themselves. He further stated that patients’ informal remarks “can be essential to gaining an understanding of the way subjects make sense of the assessment; to providing us with important information on the validity of the assessment tool; and to identifying important areas for clinical intervention” (p. 12).

It is advisable to use each and every moment with patients to try to understand who they are, where they come from, and how they are interpreting their experience in therapy. Gans (1998) links this investment to patient outcome: “our ongoing, relentless determination to understand the uniqueness of each patient is what the patient, to the degree he or she can, experiences as love . . . [and] patients who feel cared about and valued make the most gains in therapy” (p. 5). It is unrealistic to expect therapists to unravel the mysteries of a client’s contextual fabric during an arbitrarily defined assessment period. The richness of conversations that relate to personal, social, and cultural context grows as the therapeutic relationship deepens and continues to inform the intervention process.
CASE EXAMPLE

Appreciating Context During Assessment

**Occupational Therapy Assessment Process**

**Objectives**

- Understand the patient's diagnosis or condition
- Know the person
- Appreciate the context
- Develop provisional hypotheses

**Clinical Reasoning Process**

- "Mrs. N.'s complaints and presentation are certainly consistent with a brain injury. It appears that she did not seek medical attention immediately after the accident and that she has never received any rehabilitation services. These symptoms must be frightening for her."
- "It is going to be challenging for me to try to get to know Mrs. N. and to provide the kind of encouragement and support that I feel is so important to my approach with patients, given our language barriers."
- "I realize that I need an assessment strategy that is different from what I am used to. It would not make much sense for me to rely on scores from standardized tests. I will also be sensitive to the fact that it's possible that some of what Mrs. N. says to me may be lost in translation."
- "My guess is that some of Mrs. N.'s problems can be attributed to brain injury but I wonder what effect anxiety and/or depression may have on her overall functioning."

**Patient Information**

Mrs. N., a 30-year-old wife and mother of three young children, was referred to outpatient occupational therapy for assessment and treatment approximately 6 months after a suspected brain injury. She was injured when a shelf at a convenience store broke and its contents fell on her head. After the accident, Mrs. N. frequently complained of headaches, fatigue, and dizziness accompanied by dramatic decrease in her activity level and was observed to be forgetful, even unsafe (e.g., leaving stove burners turned on, losing track of her children, forgetting to take medication). With a high school education, Mrs. N. worked full time as a teaching assistant at a day care center but was unable to return to work following her injury. As a recent immigrant from Saudi Arabia, Mrs. N. spoke very little English. (She speaks and writes in Arabic.) The consulting neuropsychologist opted not to perform a battery of standardized cognitive assessments because of concerns about communication, cultural biases of the tests themselves, and possible religious discomfort associated with spending hours of assessment time with the neuropsychologist, a man. Therefore, assessment and observations in occupational therapy were particularly important in establishing her rehabilitation needs.

**Assessment Process**

Mrs. N. appeared to doze in the waiting room prior to her initial occupational therapy session. She was cooperative and soft spoken; she was able to respond in English to approximately 30% of the questions. She stayed awake for most of each of the three 1-hour assessment sessions. Mr. N., also a native of Saudi Arabia, served as translator but often dominated interactions with details of his own stress related to his wife's status. He appeared to be on the verge of tears on at least two occasions as he described his inability to work full time because of his wife's need for supervision, assistance, and transportation to medical appointments.

- Consider evaluation approach and methods
  - "I think that I can learn the most about Mrs. N.’s functioning with a dynamic assessment approach—observing her response to various demands and challenges that I set up."
Patient’s and Husband’s Report of Abilities and Limitations

Through her husband, Mrs. N. indicated that she was primarily concerned about her memory and endurance and that her ultimate goals were to completely resume her roles as mother, homemaker, and worker. (At the time of her assessment, Mr. N. prepared all of the family meals, and their oldest daughter, age 9, did most of the household chores.) Through her husband, Mrs. N. indicated that she had very little activity or routine in her day. She woke anywhere between 8:00 AM and noon. After rising, she sat for approximately half an hour, avoiding movement so as to avoid dizziness. She did not prepare meals for herself, eating only a cookie with tea instead of breakfast or lunch. She typically spent her afternoons napping, sitting alone at the window, or watching television. She fell asleep at approximately 9:00 PM, but her husband reported that he regularly found her crying in the middle of the night. Her inactivity contrasted dramatically with reports of her premorbid status: working full time, attending language and driving classes, managing all household tasks, caring for her children, and socializing with friends.

With the patient’s permission, the therapist also contacted Mrs. N.’s American-born, English-speaking sister-in-law, who confirmed the dramatic decline in Mrs. N.’s activity level and abilities, Mr. N.’s understandable stress given these changes, and her own willingness to serve as a resource.

Observations of Cognitive Function

Mrs. N. performed the Contextual Memory Test (CMT) (Toglia, 1993), a test of immediate and delayed recall of 20 pictures associated with morning hygiene. Her performance on this test suggested moderate memory deficits but adequate awareness of these limitations. Her husband translated instructions to a 10-step task to which she jotted notes. After a 25-minute delay and interference activities, she was able to use her own notes to carry out the task with 70% accuracy. She appeared to make errors because she did not carefully review her notes and approached two steps in what appeared to be a hasty and impulsive manner.

Observations of Performance of Functional Tasks

The therapist requested that Mrs. N. select a familiar stove-top meal to prepare in occupational therapy and asked her to bring necessary supplies and ingredients to one of her assessment sessions. Mr. N. reportedly reminded Mrs. N. to do so. As instructed by the therapist, Mrs. N. made an obvious effort to remember to turn off the stove burner once she finished preparing her dish. She sat next to the stove throughout the task, but having removed the pan from the stove to serve the food, she did not return to turn off the burner (which was left on for 5 minutes, until the therapist turned it off). She appeared well organized in her approach to the task, removing all ingredients and supplies from the cupboard ahead of time and cleaning up as she proceeded. Despite these efforts, she forgot to add one of the ingredients she had set out on the table and asked the therapist whether she had added another.

“Descriptions of Mrs. N.’s premorbid activities and her self-reports of long-term goals contradict my assumptions about Muslim women from the Middle East. Prior to meeting Mrs. N., I expected that Mrs. N.’s narrow sphere of activities would center exclusively on her home and children. Mrs. N.’s premorbid engagement in work outside of her home and language and driving lessons and her goals to return to these roles reminds me of the importance of trying to understand each patient as an individual rather than drawing conclusions based on cultural or ethnic stereotypes.”

“It is helpful to get a snapshot of Mrs. N.’s functioning through her husband and her sister-in-law. I feel fairly confident that I’m following all that Mr. N. is telling me, as his sister-in-law tells me much the same thing.”

“I know that I am supposed to follow the CMT’s administration protocol, but under these circumstances, I just can’t. However, the picture format of this test might give me a sense of her ability to learn new information. I appreciate that the veracity of assessment findings are in question, as all responses were reported through her husband.”

“I thought it would be a good idea to have Mrs. N. prepare a familiar dish so as to remove at least one novelty variable. I am impressed that she is willing to try every activity that I propose and that says a lot to me about her motivation to use therapy to improve her functioning.”
Mrs. N. frequently requested rest during occupational therapy sessions that entailed physical activity. She generally tolerated approximately 5 minutes of standing or walking before requesting to sit and rest because of fatigue and dizziness. During one of the three sessions, Mrs. N. complained of headache and intermittently rested her head on the table.

**Analysis of Results**

Mrs. N.’s performance of functional tasks in occupational therapy seemed consistent with the kinds of problems reported at home by Mrs. N., her husband, and her sister-in-law. Specifically, Mrs. N.’s performance on pencil-and-paper and kitchen tasks were marked by forgetfulness, absent-mindedness, and poor endurance. Furthermore, given her dramatic decline in activity, reports of frequent crying, and decreased appetite, the therapist was concerned about depression. Given his own stress, the therapist questioned whether Mr. N. would be able to maintain all of the roles he had assumed since his wife’s injury.

The following recommendations were suggested as pre-requisite to commencing occupational therapy treatment:
- Referral to a woman psychologist for further evaluation and treatment of possible mood disorder.
- Referral to a neurologist specializing in balance disorders (she had never had this complaint exhaustively evaluated).
- Schedule of a family conference with Mrs. N.’s sister-in-law, brother-in-law, and attorney to make arrangements to assist Mr. N. at home, enabling him to put in more hours at work.
- Work with the hospital patient representative to provide a translator for future occupational therapy sessions.
- Schedule an occupational therapy home safety evaluation.

**Occupational Therapy Problem List**

1. Decreased memory and concentration capabilities and inadequate strategies to compensate for these problems.
2. Deconditioning associated with prolonged inactivity complicated by poor nutrition.
3. Lack of structure or routine for daily activities and inability to judge independently which tasks were within her competence level.

**Synthesize results**

“I have addressed similar issues with other clients, and I am confident I can help Mrs. N. address these problems as well.”

**CLINICAL REASONING IN OCCUPATIONAL THERAPY PRACTICE**

**Adapting Assessment to Contextual Factors**

The occupational therapist working with Mrs. N. used only one standardized assessment tool because of concerns related to language barriers and cultural biases. How might the assessment have been different if Mrs. N. had presented the same symptoms and complaints but was born in Pittsburgh and spoke English all of her life?”
### Assessment Table 10-1

**Assessing Personal, Social, and Cultural Contexts**

<table>
<thead>
<tr>
<th>Instrument and Reference</th>
<th>Description</th>
<th>Time to Administer</th>
<th>Validity</th>
<th>Reliability</th>
<th>Sensitivity</th>
<th>Strengths and Weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Rapid Estimate of Adult Literacy in Malaise (REALM) (Murphy et al., 1993)</strong></td>
<td>Reading recognition test that allows clinicians to estimate patients’ reading skills.</td>
<td>2–3 minutes.</td>
<td>Concurrent validity: significant correlation ($p &lt; 0.0001$) between REALM and standardized measures of reading, including the Peabody Individual Achievement Test–Revised ($r = 0.97$), Wide Range Achievement Test–Revised ($r = 0.88$), and Slosson Oral Reading Test–Revised ($r = 0.96$) (Davis et al., 1993).</td>
<td>Excellent test-retest reliability ($r = 0.99$, $p &lt; 0.001$).</td>
<td>No information.</td>
<td>Strengths: Brief; minimal training needed. Weakness: Assesses literacy in English only.</td>
</tr>
</tbody>
</table>

| **CAGE Questionnaire (Ewing, 1984)** | Involves asking 4 questions to persons seeking medical services to identify possible alcohol abuse. | 5–10 minutes. | Convergent validity for 4 CAGE questions with alcohol-related items of the Army’s Health Risk Appraisal ranged from $r$ coefficient $0.1713$ to $0.3496$ (moderately weak). Criterion validity: persons with cut-off score of 2 were at 3.5 times greater risk for military discharge due to alcoholism (Bell et al., 2003). | Good test-retest reliability (2–30 days) for 4 questions ($r$ ranged from $0.73$ to $0.83$) (Bell et al., 2003). | In a study of individuals with traumatic brain injury, specificity and sensitivity of CAGE were high (86% and 91%, respectively) (Ashman et al., 2004). | Strength: Appropriate for use with clinical populations. Weaknesses: Poor sensitivity when modified to detect drug abuse or when used to determine pre-injury substance abuse (Ashman et al., 2004); CAGE was shown to be unable to discriminate between heavy drinkers and non-heavy drinkers in the general population (Bison, Nadeau, & Demers, 1999). |

*continued*
Assessment Table 10-1

Assessing Personal, Social, and Cultural Contexts (continued)

<table>
<thead>
<tr>
<th>Instrument and Reference</th>
<th>Description</th>
<th>Time to Administer</th>
<th>Validity</th>
<th>Reliability</th>
<th>Sensitivity</th>
<th>Strengths and Weaknesses</th>
</tr>
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<tbody>
<tr>
<td>Visual Analog Scale (VAS) to measure pain (Huskisson, 1974)</td>
<td>Presented as a 10-cm line, anchored with “no pain” on one end of the continuum and “worst imaginable pain” on the other end. Patient marks a line to indicate pain intensity, which is measured in millimeters (with zero at the “no pain” anchor).</td>
<td>Approximately 2 minutes.</td>
<td>High correlation between VAS and numerical rating scale for pain ($r = 0.94$; 95% CI, 0.93–0.95) (Bijur Latimer, &amp; Gallagher, 2003).</td>
<td>High reliability (intraclass correlation coefficient for paired VAS scores = 0.97; 95% CI, 0.96–0.98) (Bijur, Silver, &amp; Gallagher, 2001).</td>
<td>Statistically significant differences between changes in VAS scores (in mm) by verbal descriptors of pain ($F = 79.4$, $p &lt; 0.001$) (Gallagher et al., 2002; Pizzi et al., 2005).</td>
<td>Strengths: Brief screening tool; widely used and understood by patients and professionals. Weaknesses: Limited research regarding reliability and validity with rehabilitation populations; may not be reliable measure of pain in patients with cognitive impairments (Williamson &amp; Hoggart, 2005); not an appropriate tool for analyzing differences in pain across individuals (Kane et al., 2005).</td>
</tr>
</tbody>
</table>
### The Hospital Anxiety and Depression Scale (HADS) (Zigmond & Snaith, 1983)

- **Description:** Self-administered questionnaire designed to detect depression and anxiety in a medical outpatient clinic setting. Comprised of 16 questions related to psychological rather than somatic complaints.
- **Time:** Less than 20 minutes.
- **Correlation:** Moderate correlation between patient self-ratings on HADS and psychiatric interview assessment for anxiety ($r = 0.54, p < 0.05$) and moderately strong for depression ($r = 0.79, p < 0.01$).
- **Reliability:** Good internal consistency (Cronbach’s $\alpha = 0.83$ for anxiety subscale and 0.84 for depression subscale) (Pallant & Bailey, 2005).
- **Validity:** Good sensitivity and specificity for separate subscales with cut-off score of $\geq 8$ (HADS-anxiety: sensitivity, 0.89; specificity, 0.88; HADS-depression: sensitivity, 0.80; specificity, 0.88) (Olssøn, Mykletun, & Dahl, 2005).

### McGill Pain Questionnaire (MPQ-SF) (Melzack, 1987)

- **Description:** Self-report tool designed to measure pain and response to intervention that has 3-part dimensions: SF (word identification), Pain Intensity Index (PII), and VAS.
- **Time:** 2-5 minutes.
- **Correlation:** Moderately strong to strong correlation between subscales of SF and long form (Melzack, 1975) for 4 diagnostic groups ($r = 0.65-0.88, p < .001$). Persons with disability use many but not all of the pain descriptors included in the MPQ-SF when verbally describing their pain experience (Dudgeon et al., 2005).
- **Reliability:** Strong inter-rater reliability (intra-class correlation coefficient of 0.98 when MPQ-SF was readministered within 5 minutes by a second therapist) (Gridley & van den Dolder, 2001).
- **Validity:** Responsive to pain-related intervention. Statistically significant differences before and after intervention with 3 diagnostic groups on 3 components of test (SF, $p < 0.001$, PII, $p < 0.001$, VAS, $p < 0.001$) (Melzack, 1987).

### Strengths:
- Brief; measures quality of the pain in addition to intensity.
- Patient must be able to read.

### Weaknesses:
- Melzack (1975) cautions that simply asking the patient to fill out the questions by him or herself may yield unreliable information and suggests that the clinician read each subset of questions/instructions to the patient. Patient must be able to read.

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## Assessment Table 10-1

### Assessing Personal, Social, and Cultural Contexts (continued)

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<th>Description</th>
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<th>Validity</th>
<th>Reliability</th>
<th>Sensitivity</th>
<th>Strengths and Weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beck Depression Index (BDI) – FastScreen for Medical Patients (Beck, Steer, &amp; Brown, 2000)</td>
<td>Self-report tool that screens for depression in adults and adolescents. Comprised of 7 items extracted from the 21 item Beck Depression Inventory II.</td>
<td>Less than 5 minutes to complete.</td>
<td>Construct validity: moderately strong correlation between BDI-FastScreen and HADS ($r = 0.62$, $p &lt; 0.001$). Good internal consistency (alphas for family practice, internal medicine, and pediatric patients were 0.85, 0.85, and 0.88, respectively) (Beck, Steer, &amp; Brown, 2000). BDI-FastScreen cut-off score of ≥ 4 had 100% sensitivity and 84% specificity rates (Scheinthal et al., 2001).</td>
<td></td>
<td></td>
<td>Strengths: Very brief with good psychometric properties; responses to BDI-FastScreen not related to sex, ethnicity, age, or total number of medical conditions (Beck, Steer, &amp; Brown, 2000). Weaknesses: Does not specifically inform occupational therapy intervention planning; serves only to identify persons in need of referral for more in-depth psychiatric assessment.</td>
</tr>
<tr>
<td>Norbeck Social Support Questionnaire (NSSQ) (Norbeck, Lindsey, &amp; Carrieri, 1981)</td>
<td>Self-administered questionnaire consisting of 9 items. Patients list individuals in their personal network and specify the nature of their relationship. Measures 3 functional types of social support (affect, affirmation, and aid).</td>
<td>Approximately 10 minutes.</td>
<td>Results of factor analysis support a 3-factor model (affect, affirmation, aid) ($\chi^2 = 8.42, df = 6, p = 0.208$) (Gigliotti, 2002). (Note: A significant chi-square test suggests that variables are not independent. In this study, the results were not significant.)</td>
<td>High degree of test-retest reliability (0.85-0.92). High internal consistency within 3 types of support (0.89-0.97) (Norbeck, Lindsey, &amp; Carrieri, 1981).</td>
<td>No information.</td>
<td>Strengths: Based on conceptual definitions of social support proposed by Kahn (1979); instrument may provide useful structure for interviewing clients about the nature of their social support. Weakness: Specific subscale scores may be more relevant to research than practice.</td>
</tr>
</tbody>
</table>
Assessing Context: Personal, Social, and Cultural

1. Consider your morning self-care routine—the activities you performed today to get ready to leave for school or work. List the personal, social, and contextual factors that influenced your performance. If someone who did not know you judged your performance, what aspects might they consider unusual? What aspects might he or she consider normal for someone of your age and background?

2. Review Figure 10-2 and write a paragraph describing the possible influences on occupational functioning of one of the contextual factors not discussed in this chapter. For example, how might social class or gender help or hinder performance?

3. Outline circumstances in which you would use standardized instruments to assess contextual factors and those in which you would use more informal methods.

4. Make a private list of your own biases. What assumptions do you have about people who are different from you in terms of age, sex, cultural and educational background, sexual orientation, and abilities (physical, cognitive, emotional)? List the steps you can take to debunk these biases and measures to minimize their effects during interactions with patients.

5. Observe the interactions of another clinician and patient during assessment. What, if any, comments made by the therapist could be attributed to his or her personal, social, and cultural context? What comments made by the patient could be attributed to his or her personal, social, and cultural context?

References


Watson, N. (2002). Well, I know this is going to sound very strange to you, but I don’t see myself as a disabled person: Identity and disability. *Disability and Society, 17*, 509-527.


**Supplemental References**