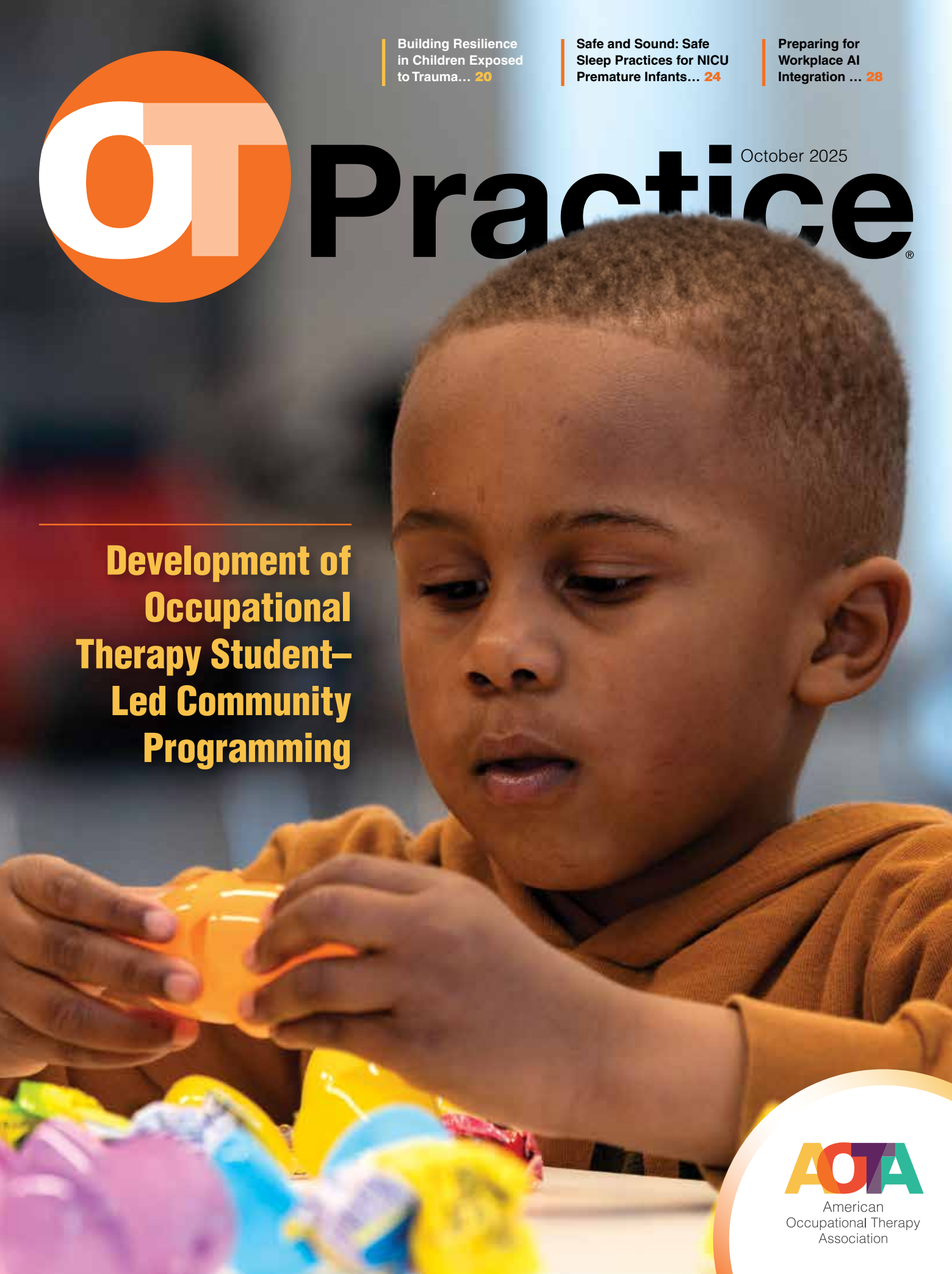
OT Practice®

October 2025

Development of Occupational Therapy Student–Led Community Programming



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Fall Into Practice:
Harvesting Ideas

As autumn settles in and the days grow shorter, many of us may be embracing the thought of cooler weather, bonfires, hot chocolate, and football season. This time of year can also be a time to reflect on the evolving landscape of occupational therapy.

In this issue, you'll find stories that highlight innovations in community-based practice, the integration of technology into the workplace, and specialized interventions for children and youth—among others.

Amy Hudkins and Kerri Golden explore how occupational therapy interventions can enable clients to regain control of their lives during challenges they face with seasonal affective disorder (p. 30).

Marla Davis shares her journey of getting back to occupational therapy's roots and engaging with arts and crafts, and how this can support overall mental health, specifically in terms of burnout. (p. 33).

Gabrielle Gelfen puts forth that by helping clients become informed consumers of AI, OTPs can reinforce client-centered care while strengthening clinical rapport (p. 28).

Katelin Kearney, Lisa Bader, and Ryan Olson-Meyer show how OTPs play an important role in carrying out current practices and educating parents on the importance of safe sleep to reduce the risk of sudden infant death syndrome (p. 24).

October can also be a time of planning. Whether you're preparing for conferences, beginning to set goals for 2026, or selecting key webinars, this can be a good time to recommit to the values that ground the profession: client-centered care, evidence-based practice, and a belief in the power of occupation to transform lives. AOTA provides many opportunities for professional and personal growth, and you can explore the offerings here (https://www.aota.org/career/continuing-education).

Thank you for continuing to be a part of the occupational therapy and AOTA communities.

All the best,

Lisa Gwaltney
Editor, *OT Practice*
lgwaltney@aota.org

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- Go to **www.aota.org/publications/ot-practice** to read *OT Practice* online.
- Visit our website at **www.aota.org** for contributor guidelines, and additional news and information.

OT inside

The American Occupational Therapy Association (AOTA)
Volume 30 • Issue 10 • October 2025

Features

AOTA American Occupational Therapy Association

OT Practice (ISSN 1084-4902) is published 12 times a year by The American Occupational Therapy Association, Inc., 7501 Wisconsin Avenue, Suite 510E, Bethesda, MD 20814-6519; 301-652-2682. Periodical postage is paid at Bethesda, MD, and at additional mailing offices.

U.S. Postmaster: Send address changes to *OT Practice*, AOTA, 7501 Wisconsin Avenue, Suite 510E, Bethesda, MD 20814-6519.

Canadian Publications Mail Agreement No. 41071009. Return Undeliverable Canadian Addresses to PO Box 503, RPO West Beaver Creek, Richmond Hill ON L4B 4R6.

Mission statement: The American Occupational Therapy Association advances occupational therapy practice, education, and research through standard setting and advocacy on behalf of its members, the profession, and the public.

Annual membership options are Basic: $163 for OTs, $137 for OTAs; Plus: $234 for OTs, $208 for OTAs; Premium: $714 for OTs, $643 for OTAs; Student: $78, of which $14 is allocated to the subscription to this publication. Subscriptions in the U.S. and Canada are $275 for individuals and institutions. Subscriptions outside the U.S. and Canada are $375 for individuals and $430 for institutions. Allow 4 to 6 weeks for delivery of the first issue.

Departments

OT Updates

IN MEMORIAM

Akiko Suzuki

With deep sorrow, the Japanese Association of Occupational Therapists (JAOT) shares the news of the passing of Dr. Akiko Suzuki in July 2025. Dr. Suzuki was our very first Certified Occupational Therapist in Japan, and she contributed significantly to the establishment of JAOT and became JAOT's first President. She had been a member of AOTA since 1963.

Dr. Suzuki graduated and was qualified by the Occupational Therapy Certificate Course at Columbia University in the United States and received the Outstanding Professional Achievements award in 1991 at its 50th Anniversary.

She also completed her Master of Science at Boston University in 1973, and Doctor of Philosophy at Wayne State University in 1982.

Having studied occupational therapy in the United States, Dr. Suzuki made a profound contribution by strengthening Japan's occupational therapy profession, becoming a pioneer in connecting Japan and the world. She was the most influential therapist in establishing the foundations of occupational therapy in Japan.

We will always be grateful for Dr. Suzuki's life and legacy. May her memory continue to inspire us, and may she rest in eternal peace. With respect and remembrance,

*— **Shinichi Yamamoto**, President*
***Jumpei Oba**, WFOT Delegate*
Japanese Association of Occupational Therapists

AOTA news & events

The AOTA Specialty Conference: Women's Health will be held October 10 to 11, in Portland, OR. Preconference sessions will take place October 9. Explore the latest in women's health, including maternal health, menopause, women in sports, eating disorders, and more (https://www.aota.org/events/calendar/aota-specialty-conference-womens-health).

The AOTA 2026 election nominations window will close October 16, 2025. https://www.aota.org/events/calendar/elections-nominations

The Education Summit will be held in Salt Lake City, UT, November 14 to 15. Pre-conference sessions will take place November 13. Connect with other academics and educators to elevate your teaching and enhance student success at your institution! *Early Bird pricing ends October 30* (https://www.aota.org/events/calendar/education-summit).

The AOTA Specialty Conference: Children & Youth will be held December 12 to 13 in Charlotte, NC. Pre-conference sessions will take place December 11. Learn and network with other pediatric OT practitioners, with sessions on everything from sleep and sensory regulation, to assistive technology and caregiver coaching. *Early Bird pricing ends November 10* (https://www.aota.org/events/calendar/aota-specialty-conference-children-and-youth).

PRACTICE IN ACTION

AOTA's New Quality Measures Webpage

Celebrate Healthcare Quality Week from October 19 to 25, by visiting AOTA's new Quality Measures webpage (https://bit.ly/3GZu919). Learn about the basics of quality measures, how they can be used across the lifespan, and how to identify and advocate for occupational therapy's value in addressing common areas of quality measurement. You can also access a curated list of related articles and books.

MEMBERSHIP MATTERS

Free Big Beautiful Bill Webinar

Thousands of OTs and OTAs registered for AOTA's recent webinar on the "One Big Beautiful Bill," HR 1. The recording is now available for free to the entire AOTA community, but only AOTA members can access our robust, setting-specific billing and coding tools built to help you navigate these changes. Now is the time to understand what HR 1 means for your career, and how AOTA's resources keep you a step ahead. Watch the webinar here (https://myaota.aota.org/shop_aota/product/OL9700).

SPOTLIGHT ON OT

Luis Arabit, OTD, MS, OTR/L, BCPR, C/NDT, PAM, FAOTA, Associate Professor at San Jose State University, and former AOTPAC Region V Director, received a Certificate of Recognition from the peri-Operative Registered Nurses Association of the Philippines (ORNAP), during the ORNAP's 50th Annual Convention and Scientific Meeting and 52nd Founding Anniversary held at the Manila Hotel, Manila, Philippines, in July 2025. He was an invited distinguished guest speaker and delivered the Inspirational Founder's Speech address on behalf of his grandmother, the late Mrs. Consuelo Gomez Arabit, RN, the first President and founder of the ORNAP. The convention's theme, "Celebrating Five Decades of Commitment and Collaboration: Forging a Cohesive and Exemplary Perioperative Nursing Practice," was attended by more than 8,000 Filipino registered nurses. In his speech, Luis focused on the importance of embracing innovations, maintaining continuous professional development, strengthening partnerships and interdisciplinary collaborations, and upholding ethical standards and professionalism. He also thanked ORNAP members for being an integral part of the Association's 5-decade journey of inspiration, excellence, and unity.

Jacqueline Bouillin, OTR/L, a Brain Injury Specialist, has written a new article, "Occupational Therapy's Role in Brain Injury Recovery" For the Brain Injury Association of America. The article is part of a new series that focuses on how different specializations impact rehabilitation for people with a brain injury (https://biausa.org/public-affairs/media/occupational-therapy-and-brain-injury-recovery).

Cynthia Chih-Ying Li, PhD, OTR/L, was featured in a New York Times article, "Even Grave Errors at Rehab Hospitals Go Unpenalized and Undisclosed." She discussed findings from her research showing that for-profit rehabilitation facilities are the only institutional characteristic that is significantly linked to higher rates of unplanned readmissions. As an Associate Professor at the University of Texas Medical Branch School of Health Professions, Cynthia underscored the implications of her work for transparency, accountability, and patient safety in post-acute care settings. This national media coverage amplifies the critical role occupational therapists play in advocating for quality care and system-level improvements (https://bit.ly/47jGXtH).
Credit: KFF Health News.

Noah Claypool, OTD, OTR/L, was the focus of a University of Nevada Las Vegas article about a reintegration program he developed for former prisoners (https://www.unlv.edu/news/article/occupational-therapy-alumnus-turns-class-project-reintegration-program-ex-prisoners).

In July 2025, Augusta University hosted their third annual Camp Discovery program for women who are cancer survivors. The camp is hosted by the Department of Occupational Therapy at Augusta University, led by **Pamalyn Kearney**, EdD, MS, OTR/L, FAOTA, Department Chair. The program supports women who are cancer survivors, builds community, improves quality of life, and increases engagement through meaningful activities (https://jagwire.augusta.edu/camp-discovery-offers-cancer-survivors-support-and-fun/).

Advocating to Medicaid for Coverage of Occupational Therapy Services

Kristen Neville

On July 4, President Trump signed into law legislation called the One Big Beautiful Bill Act (H.R. 1). There is strong evidence to suggest that this new law will likely have a significant impact on funding of state Medicaid programs as well as the provision of occupational therapy services to clients who are Medicaid enrollees. To keep track of potential policy changes to your state's Medicaid program, please visit your state's Medicaid agency website (https://bit.ly/4oD0N9x) and take the following action.

- Connect with your state occupational therapy association (https://bit.ly/4lrqbME)—many of which have lobbyists who know who in Medicaid to talk to about an issue—or a volunteer leader who follows Medicaid or reimbursement issues.
- Attend meetings for your state's Medical Care Advisory Committee or other public body that advises the Medicaid agency on the operation of the Medicaid program.
- Sign up to receive email notifications from Medicaid when a regulation or rule, policy, or State Plan is proposed to be changed.
- Download and review the Medicaid policy manual pertaining to occupational therapy services.
- Review Medicaid state bulletins or guidance documents for changes that could impact the provision and coverage of occupational therapy services.

PHOTOGRAPH © HAPABAPA / GETTY IMAGES

Medicaid policy can be complicated, and advocating for changes to such policies can be daunting, but AOTA is here to help. View our free webinar on the impact of the bill on occupational therapy (https://myaota.aota.org/shop_aota/product/OL9700) Reach out to the AOTA State Affairs Team (state@aota.org) for advice and answers to your questions, and visit AOTA's website (https://www.aota.org/advocacy/issues/medicaid-advocacy) for more resources.

KRISTEN NEVILLE is AOTA's Manager of State Affairs.

Medicare Finalizes Part A Payment Increases, Notes Occupational Therapy's Role in Addressing Well-Being

Jennifer Bogenrief

In late July2025, the Centers for Medicare & Medicaid Services (CMS) released final rules for Medicare Part A settings including skilled nursing facilities (SNFs), inpatient rehabilitation facilities (IRFs), hospitals, inpatient psychiatric facilities (IPFs), and hospice. CMS finalized proposed or higher than proposed 2026 payment increases for some settings, as follows:

- 3.2% increase to SNF prospective payment system (PPS) payment rates (proposed 2.8% increase)
- 2.6% increase to IRF PPS payment rates (same as proposed)
- $5 billion payment increase for inpatient hospital (proposed $4 billion)
- 2.7% payment increase for long-term-care hospital (proposed 2.6%)
- 2.4% increase to IPF PPS payment rates (same as proposed)
- 2.6% increase to hospice payment rates (proposed 2.4%)

PHOTOGRAPH © DILOK KLAISATAPORN / GETTY IMAGES

AOTA believes that stable or increased payment rates will help maintain patient access to care.

Citing efforts to reduce provider burden, CMS finalized proposals to remove data elements and quality measures related to social drivers of health (living situation, food, utilities). The final rules include summaries of feedback that CMS received in response to Requests for Information on future topics, such as well-being, nutrition, and delirium. AOTA submitted detailed comments highlighting occupational therapy's role in improving outcomes in these areas and encouraging CMS to reflect the patient's voice and use existing data elements to minimize provider burden. We were pleased to see that in the SNF final rule, CMS included occupational therapists in a list of examples of staff that may be best suited to implement and track factors related to well-being.

Also, in the inpatient hospital final rule, CMS adopted updates to the Transforming Episode Accountability Model (TEAM), the 5-year episode-based payment model mandatory for selected acute care hospitals that begins January 1, 2026. Adopted as proposed, these updates include a patient-reported outcome measure on information transfer after outpatient procedures and an expanded 3-day SNF Rule waiver eligibility for swing bed care. AOTA supported the proposal to allow TEAM participants to

use the TEAM SNF 3-day rule waiver for TEAM beneficiaries discharged to hospitals and critical access hospitals providing post-acute care for swing bed arrangements, because we believe it would protect patient access to post-acute care SNF services—especially for beneficiaries in rural and underserved areas.

As a reminder, CMS began implementing the Hospice Outcomes and Patient Evaluation (HOPE) tool on October 1, 2025 (https://bit.ly/4lsSZ7B). AOTA supports the use of the HOPE tool as a way to assess and address patients' spiritual, psychosocial, and emotional needs and goals of care. According to the HOPE Guidance manual, "HOPE may be completed by any appropriate hospice staff member, based on the data being collected" (p. 17). In our comment letter responding to the proposed hospice rule, AOTA encouraged CMS to emphasize that any qualified provider can complete HOPE, including occupational therapy practitioners (OTPs), to eliminate confusion at the hospice staff level. OTPs working in hospice should seek opportunities to promote occupational therapy's role in meeting patient needs and goals by completing the HOPE.

The final rules are lengthy and include many provisions and summaries of comments that CMS received. For more information by setting, see the CMS fact sheets, below, in "Resources."

In addition, on June 30, 2025, CMS issued its Home Health PPS proposed rule for 2026, including an overall 6.4% reduction to home health payments (or an estimated $1.135 billion) compared to 2025 (https://bit.ly/45xLtCl). CMS will publish its CY 2026 Home Health PPS final rule by early November 2025. AOTA will monitor CMS' actions and share updates.

JENNIFER BOGENRIEF, JD, is AOTA's Director of Regulatory Affairs.

AOTA Endorses Legislation Requiring MA Plans to Address Serious Reimbursement Issues for Occupational Therapy and Other Services

Andy Bopp

In July 2025, Reps. Lloyd Doggett (D-TX) and Greg Murphy, MD (R-NC) introduced the Prompt and Fair Pay Act (H.R.4559) (https://bit.ly/4ltcQ6G), legislation that would ensure that payments for occupational therapy and other services under Medicare Advantage (MA) at least match Traditional Medicare Fee-for-Service (FFS) reimbursement levels. The bill also requires prompt payment of clean claims and enhanced transparency from MA organizations regarding questioned claims. Reps. Doggett and Murphy both referred to significant issues with MA reimbursement and administrative burden during a Ways and Means Health Subcommittee hearing on July 22, 2025.

AOTA has endorsed H.R.4559, which would address many of the issues AOTA members have reported, including MA plans reimbursing at lower rates than Medicare FFS, delayed reimbursement, and erratic procedures for handling questioned claims. AOTA's Chief Executive Officer, Katie Jordan, OTD, MBA, OTR/L, FAOTA, was quoted in the Congressional press release, noting, "This legislation is critical to reduce the administrative burden related to processing claims, which would allow a greater focus on actual patient treatment."

AOTA will continue to engage with MA plans as part of coalition efforts to address specific issues with individual plans, and work with the Centers for Medicare & Medicaid Services and Congress, as they have the ultimate authority to require MA plans to provide fair reimbursement for occupational therapy and other services.

Ask your members of Congress to support this legislation (http://www.aota.org/takeaction).

ANDY BOPP is AOTA's Senior Legislative Representative.

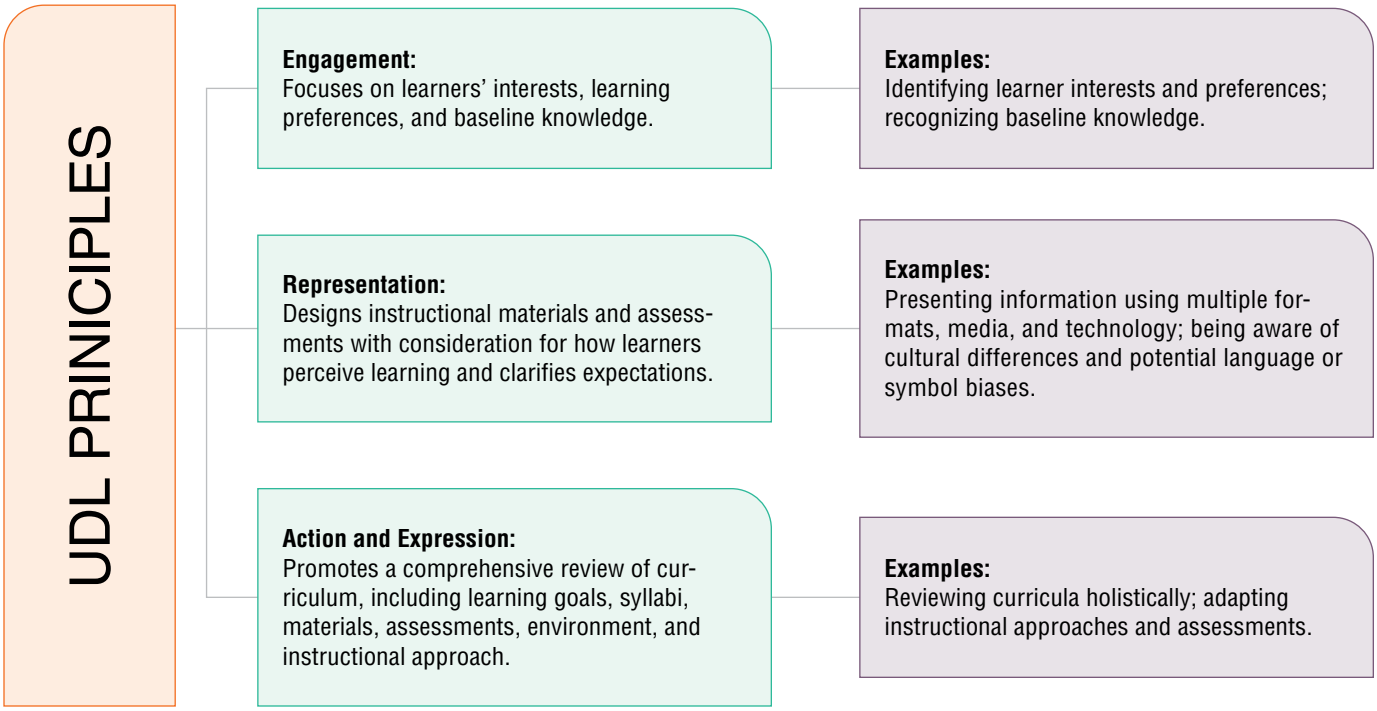
Accessibility and Inclusion in OT Education:
Universal Design for Learning

Gayla Aguilar
Rocio Alvarenga
Inti Marazita
Thais Petrocelli
Sharon Wright

Universal Design for Learning (UDL) is a foundational educational framework designed to ensure that learning is both accessible and meaningful for every learner (CAST, 2024; Meyer & Rose, 2024). In a study by Murphy et al. (2020), findings suggested that "knowledge of the UDL principles and a greater breadth and depth of instructional strategies may facilitate greater learning outcomes in occupational therapy students" (p. 302). By embracing varied learning needs, UDL creates an accessible collaborative and inclusive educational environment, fostering a sense of community and belonging among learners and educators. See Figure 1 for an overview of the UDL principles and examples for implementation.

UDL emphasizes learning environments that are accessible and adaptable while acknowledging learners who were previously considered to be on the margins of learning as an integral part of the educational structure. As such, UDL can assist occupational therapy educators in planning and designing content that accommodates the varying learning styles of occupational therapy and occupational therapy assistant students within the educational environment.

Figure 1. Three Core Principles of Universal Design and Examples



Adapted from: CAST (2024). U*niversal Design for Learning Guidelines version 3.0.* https://udlguidelines.cast.org; Gordon, 2024. *Universal design for learning: Principles, framework, and practice. CAST Professional Publishing.*

Table 1. Strategies and Examples for UDL Implementation

Strategy	Description	Example
Scaffold Learning	Allow learners to connect new concepts to their prior knowledge, building a solid foundation for deeper understanding.	Culturally responsive tiered case studies allow learners to self-select assignment formats, use synchronous sessions to bridge learning for application.
Encourage Diverse Perspectives	Tailor content to relate to learners' unique backgrounds and experiences, ensuring it resonates personally.	Culturally responsive tiered case studies, simulation, and virtual simulations.
Leverage Technology Thoughtfully	Integrate tools and resources that align with specific learning objectives to enhance outcomes.	Use educational tools such as Poll Everywhere, Kahoot, Padlet, and virtual simulations and video case studies.
Prioritize Accessibility	Make all materials universally accessible.	Utilize aids such as closed captioning, transcripts, alt text, infographics, and graphic organizers.
Facilitate Communication	Create opportunities for interaction.	Virtual office hours, group discussion, or forums.
Prepare Learners	Share instructional content in advance to encourage active participation.	Provide handouts, presentation notes, and lesson plans before class meetings.
Design Real-World Tasks	Ensure assignments mirror practical, real-life scenarios to create meaningful learning experiences.	Service learning, pro-bono Clinic, high fidelity simulations.
Promote Reflection	Incorporate reflective exercises to help learners assess their programs and refine their learning approaches.	Journaling, reflective group discussions, digital storytelling.

Adapted from: CAST (2024). *Universal Design for Learning Guidelines version 3.0.* https://udlguidelines.cast.org; Gordon, 2024. *Universal design for learning: Principles, framework, and practice.* CAST Professional Publishing.

Fostering Accessible and Inclusive Learning Spaces in OT Education

To prepare OT and OTA learners for success in today's health care environment, we must prioritize their needs and learning styles. Faculty will need to promote "learner agency that is purposeful and reflective, resourceful and authentic, strategic and action-oriented" (Meyer & Rose, 2024, p. 162). Therefore, OT and OTA educators are poised to naturally implement UDL due to the holistic approach that looks at education from a learner-centered perspective. Table 1 provides example strategies that OT and OTA educators can use to ensure that the learning environment and teaching materials are accessible to and inclusive of all learners.

Incorporating these strategies ensures that the needs of learners are always at the forefront and that they are valued in their educational journey.

Incorporating UDL principles into occupational therapy education aligns with the American Occupational Therapy Association (AOTA)'s Vision 2030, which emphasizes creating accessible supportive environments that foster "belonging, collaboration, and continuous learning" (AOTA, 2025, para.6). This approach ensures that instructional experiences remain accessible, adaptable, and responsive so that every learner can thrive.

GAYLA AGUILAR, PHD, OTD, OTR/L, has been practicing for 30 years, specializing in pediatrics and autism. She holds a PhD in Health Psychology and is the Program Director for the OTD program at Hanover College in Hanover, IN.

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INTI MARAZITA, PHD, MS, OTR/L, has been practicing for more than 28 years and specializes in pediatrics, mental health, and education. She is the Director of Occupational Therapy Academic Projects at the University of St. Augustine for Health Sciences in St. Augustine, FL.

THAIS PETROCELLI, OTD, MHA, OTR/L, has more than 21 years of experience in practicing occupational therapy, specializing in mental health, community-based programs, pediatrics, and hybrid learning. She is the Director of Fieldwork for the OTD program at Hanover College in Hanover, IN.

SHARON WRIGHT, OTD, OTR/L, has more than 30 years of experience in occupational therapy practice, specializing in adult neurorehabilitation. She is the Director of Admissions for the OTD program at Hanover College in Hanover, IN.

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obi 3

Obi is a medical robot intended to restore self-feeding for individuals with severe upper extremity mobility impairments.

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Our users have had success with receiving funding for Obi through Private Insurance, Medicaid, Veterans Administration, Advocacy Groups, AT Programs, Schools & Universities, Waiver Programs, Grants, Crowdfunding, and more!

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Usability Perspectives on Obi 3:

The next generation of Obi - a medical robot for self-feeding

Authors: Andrea D. Fairman, PhD, MOT, OTR/L, ATP, DRP, CDI & Heather Keeton, ATP

Occupational therapy practitioners often seek assistive technologies that can significantly enhance participation in daily activities. Feeding is among the most critical occupations, yet many individuals with upper extremity impairments face challenges achieving independence at mealtimes. Obi has been produced since 2016, however the latest generation of Obi, Obi 3, was recently launched in August 2025. This new generation was developed to address additional user needs with new utensil options, software features, and many other upgrades.

"It was very very user friendly...I was able to show three of his caregivers and it took us less than 10 minutes to get it set up."
- OT Provider

A recent usability study evaluated Obi 3 with 42 participants, including patients, caregivers, and providers, across pediatric and adult populations. Participants completed one-week home trials, while providers performed a before-and-after technology assessment. Outcomes included self-reported ease of use, safety, satisfaction, and impact on independence.

No serious adverse events or complaints occurred, underscoring the device's safety and quality profile. While participants also noted areas for potential refinement, overall satisfaction was strong. "Collectively, the findings underscore Obi's medical necessity by showing safety, quality, measurable improvements in self-feeding independence, and generally strong technology acceptance across all stakeholder groups."

For occupational therapy practitioners (OTPs), these findings highlight the potential of Obi 3 to enhance independence, dignity, and quality of life for individuals with feeding limitations. As assistive technologies evolve, OTs remain central in matching devices to client needs, training users, and monitoring outcomes to ensure optimal integration into daily life.

"She's so motivated by it... she loves using it... she's so proud that she is feeding herself!"
- Caregiver

Results Were Striking:

- Patients reported significant reductions in self-feeding impairment, with many moving from severe dependence to mild or no impairment after one week of use by applying an adapted ICF framework for functional eating (WHO, 2001).
- Caregivers described decreased burden and greater confidence in their child or family member's ability to eat independently.
- Providers rated usability exceptionally high, with System Usability Scale (SUS) scores well above average benchmarks (Lewis, 2018).
- Across all groups, participants emphasized improved independence, safety, and mealtime participation.

Key Takeaways:

- Obi 3 promotes **independence and dignity** for clients with feeding limitations.
- Strong usability scores from patients, caregivers, and providers support **ease of learning and safety.**
- Caregiver **burden was reduced**, and confidence in client abilities improved.
- OTPs found the Obi trial and assessment process to be both clinically effective and efficient.

To learn more about Obi, please visit: www.MeetObi.com

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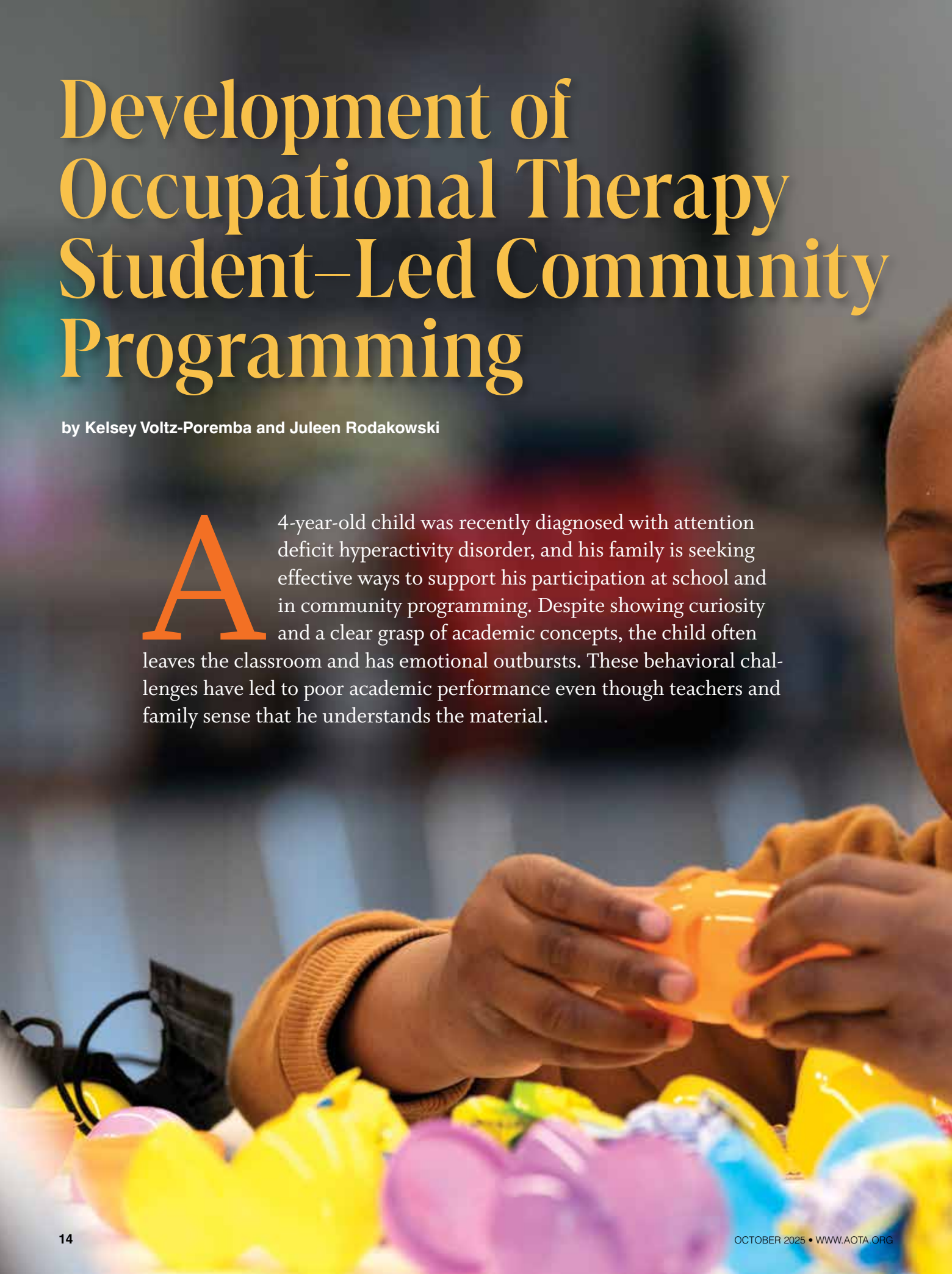
Development of Occupational Therapy Student–Led Community Programming

by Kelsey Voltz-Poremba and Juleen Rodakowski

A 4-year-old child was recently diagnosed with attention deficit hyperactivity disorder, and his family is seeking effective ways to support his participation at school and in community programming. Despite showing curiosity and a clear grasp of academic concepts, the child often leaves the classroom and has emotional outbursts. These behavioral challenges have led to poor academic performance even though teachers and family sense that he understands the material.



A Hope for Handwriting participant engages in fine motor activities to support his handwriting goals.

The family is prioritizing nonpharmacological approaches before considering medication. However, accessing these services has proven difficult. The child does not meet the age requirements for the early intervention system and has faced delays and barriers in receiving a school evaluation and an individualized education program, and local outpatient centers have been far away, have had long waitlists, or have been financially burdensome.

In situations like this, community-based programming can play a vital role in filling the gaps. These programs can support families and individuals with needs that occupational therapy practitioners (OTPs) are uniquely trained to address. With its holistic and client-centered approach, occupational therapy empowers individuals to participate in meaningful activity and overcome systemic barriers.

This article showcases an innovative example from the Homewood community in Pittsburgh, Pennsylvania, where occupational therapists (OTs) and faculty at the University of Pittsburgh have partnered with a local organization to increase access to support services. Through programs like Hope for Handwriting, OTs show how targeted, community-driven interventions can provide a robust hands-on learning experience for occupational therapy students and build confidence, support emotional regulation, and promote resilience among children.

Filling the Gap for Community Youths

OTPs are innately skilled and prepared to meet our patients and clients where they are in the stages of recovery, disability, or illness. OTPs possess expertise in understanding the dynamic relationship among person, environment, and occupation, allowing them to develop unique, client-centered interventions that enhance participation and quality of life. Moreover, OTPs have endorsed a broad and holistic perspective that goes beyond medical models of care, creating an important role in promoting the health of populations (Domholdt et al., 2020). This holistic approach, combined with OTPs' unique understanding of how environments affect participation, makes occupational therapy a natural fit for the development and delivery of community-based services.

Occupations occur within communities, and by actively participating in community-based services, OTPs can be "in the room where it happens," expanding their reach to diverse populations. Access to traditional services can be restrictive, specifically in communities where services do not exist or where

PHOTOGRAPH © UNIVERSITY OF PITTSBURGH

"Not only was Hope for Handwriting program filling a gap identified in the community, but it also was showcasing the unique role occupational therapy has in promoting participation in education..."

patterns of social determinants of health are negatively affecting the population's health and well-being (Xiao et al., 2023). Community-based programming for youths helps address the barriers faced by the family of the rambunctious 4 year old and other families like them. By bringing services to communities where they previously did not exist, leveraging the skills of occupational therapy students, and removing eligibility criteria, programs allow individuals who might otherwise not access occupational therapy services to benefit from the effects of this profession.

Working with youths in the community seemed like a perfect fit because the University of Pittsburgh's Department of Occupational Therapy already had established connections in the community elementary schools and with Homewood Children's Village, a nonprofit organization. A plan was made to leverage the existing collaboration with community youths and utilize a newly built community space in Homewood, sponsored by the University of Pittsburgh, to create after-school programming supporting the Homewood community's goal of expanding quality out-of-school time options (Homewood Community Development Collaborative, 2020).

Two youth programs, Beyond the Bell and Hope for Handwriting, were initially designed to be delivered at the School of Health and Rehabilitation Sciences (SHRS) Wellness Pavilion at the university's Community Engagement Center. All services and programs at the SHRS Wellness Pavilion are provided at no or low cost to the Homewood and surrounding communities. Beyond the Bell is a group-based, after-school program promoting health and wellness for elementary students, and Hope for Handwriting is a one-on-one class designed to address handwriting challenges through improving fine motor, visual–motor, or sensory–motor skills (see Table 1).

Although both programs were successful and well attended, Hope for Handwriting stood out as particularly effective. Community members praised the program as truly unique—the first of its kind in the community. As the program expanded, a recurring theme emerged from participants and their families: Many reported believing that their children were not receiving adequate handwriting support in school. Families also reported that they felt schools were leaning into technology (especially after the COVID-19 pandemic) and that the skill of handwriting was not emphasized because of increased typing, driven largely by children having personal laptops or tablets provided by their schools.

Not only was Hope for Handwriting program filling a gap identified in the community, but it also was showcasing the unique role occupational therapy has in promoting participation in education through the support of fine motor, visual–motor, and sensory–motor skills. This initiative became a win–win, meeting a realized need within the community while offering occupational therapy students a chance to advocate for the profession in a student-led, community-based setting.

Table 1. Goals of Youth Community Programming, by Program

Program	Style	Goals
Beyond the Bell	Group	• Promote physical and emotional health and wellness. • Engage participants in activities to better understand health and wellness. • Support participants with out-of-school activities to increase participation in formal education (homework and studying help).
Hope for Handwriting	One-on-one	• Support fine motor, visual–motor, and sensory–motor skills that are affecting positive participation. • Build confidence in ability to communicate through written communication. • Increase participation in formal education, particularly activities that require handwriting.

Implementing Hope for Handwriting

Hope for Handwriting is structured similarly to a traditional pediatric occupational therapy session. Participants sign up for a 45-minute time slot to meet one-on-one with an occupational therapy student. The initial session consists of a handwriting screen using a modified version of the Evaluation Tool of Children's Handwriting (Amundson, 1995). Children typically participate in the program for 8 weeks, meeting weekly with an occupational therapy student to engage in personally tailored activities. For example, if an individual has trouble displaying a functional grasp on the writing utensil during their assessment, their sessions will focus on fine motor strength and coordination. If another child struggles with attention or sensory regulation, the intervention may include sensory strategies to improve their focus and engagement.

In addition to the direct services, the program equips families with strategies to facilitate skill development at home. This emphasis on family involvement is essential because the program is time limited, with 8-week sessions offered twice yearly in the fall and spring semesters.

Growing Through Community Collaboration

Although the primary goal of programming is to support the community, an equally important secondary goal is

A Hope for Handwriting participant completes a handwriting worksheet with an OT student.

to create a space where occupational therapy students can connect with the community and develop clinical skills. Both Beyond the Bell and Hope for Handwriting were embedded within the Level I fieldwork curriculum; however, Hope for Handwriting transformed into a strong platform for doctoral capstone students to immerse themselves in community engagement and deepen their clinical knowledge in pediatric practice.

Students who completed their capstones through the program reported increased confidence, enhanced clinical reasoning, and strengthened leadership skills. One student who completed their doctoral capstone with Hope for Handwriting in spring 2023 reported their thoughts about the long-term effects of the experience: "I still look back at the program and reflect on the skills I was able to develop, and I use to this day with the kids I work with!" The program serves a dual purpose: providing accessible services in the community that meet real needs, while offering occupational therapy students transformative hands-on experiences that support their growth as future practitioners.

"Students who completed their capstones through the program reported increased confidence, enhanced clinical reasoning, and strengthened leadership skills."

Building Confident and Successful Youths

By the age of 5, one would expect to see a child remain on task for 5 to 10 minutes, be able to display a dynamic grasp, copy basic shapes and prewriting strokes, and even trace their name (Teaford et al., 2010). When we first met our lively 4 year old (introduced in the beginning of this article), he was a few months shy of turning 5 and struggled to complete most of those things, notably the ability to attend to and remain on task. Because of this inattention, he often rushed through tasks, drawing letters and shapes that took up an entire page of paper running onto the table, scribbling furiously on a coloring page, and displaying immature grasps. His frustrations would even sometimes lead to him ripping paper and throwing his writing utensil.

In this child's Hope for Handwriting sessions, we first targeted the environment, using a quiet space with minimal distractions. We implemented a visual schedule and routine. When he knew what to expect in a session, we found he was more engaged and happier to be there. It was clear he frequently was seeking sensory input; he stomped around the center and liked deep hugs. We harnessed this knowledge and developed a sensory routine at the beginning of each session that targeted proprioception. By implementing these sensory and behavioral

An OT student works on a letter formation worksheet with a Hope for Handwriting participant.

strategies at the beginning of his sessions, the rest fell into place. He was more understanding of the concepts and was able to happily take direction to address the other developmental concerns when he was regulated and ready to learn. We worked with the family on ways to implement the techniques at home and how to instruct their child's educators to do the same. Soon, these strategies began to help him participate in fine motor and writing activities more independently, not only in the program but at school and at home.

This high-spirited child began participating in Hope for Handwriting program in spring 2022. Now 7 years old, he has made remarkable strides and is one of the program's longest participants.w A child who was merely surviving his day at school is now thriving. His mother shared the effects the program has had on multiple areas of his development: "Every time he participates, I notice his confidence growing with his writing skills, his reading skills, his ability to position his fingers appropriately, which has helped strengthen his fingers with playing the piano and violin." The child also reported having positive experiences from the program, saying that "every single thing" in the program was valuable to him. He especially recalled how the program helped him remember and write his capital letters. When reflecting on their participation in the program, his mother said,

> When he started the program, he wrote BIG and oftentimes not legibly—with a lot of personality. Through his years of participation, he has started to mature with his writing style and has gained confidence with writing sentences and stories. I have witnessed a tremendous impact on his growth from a young boy that did everything BIG and carefree to a 7-year-old boy that loves to pick up a writing tool to create clear and intentional pieces of art. I am proud of his progress and his love for writing and reading.

Recently, this child took a break from the program. His handwriting had improved so that he was able to keep pace with his peers in school, and he was excited about violin lessons. Although we miss his joyful energy, his success is a reminder of exactly why Hope of Handwriting was created: to foster growth not only in academic performance but in meaningful participation beyond the classroom. He is just one of many participants who can showcase the value of community-based occupational therapy services.

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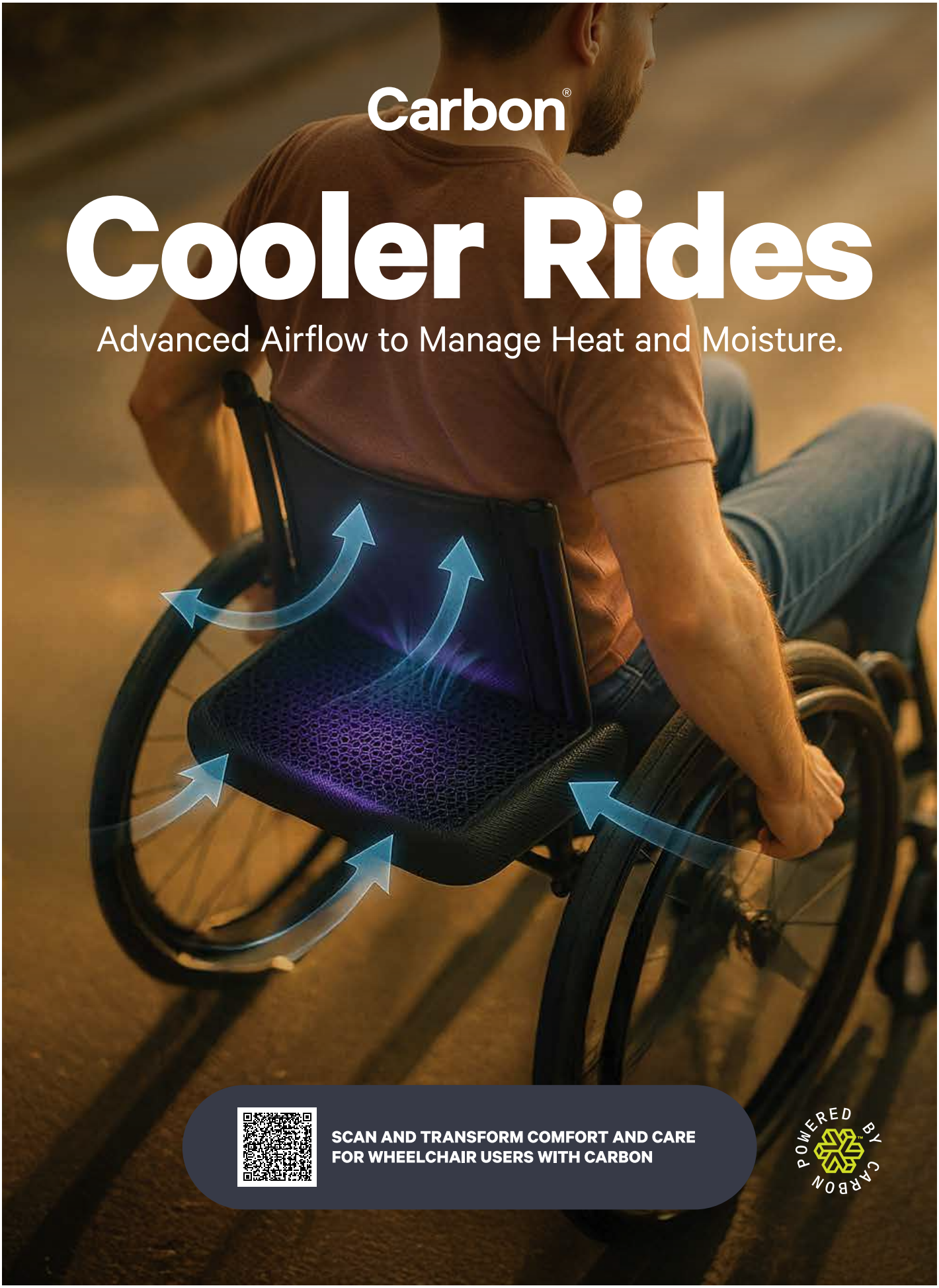
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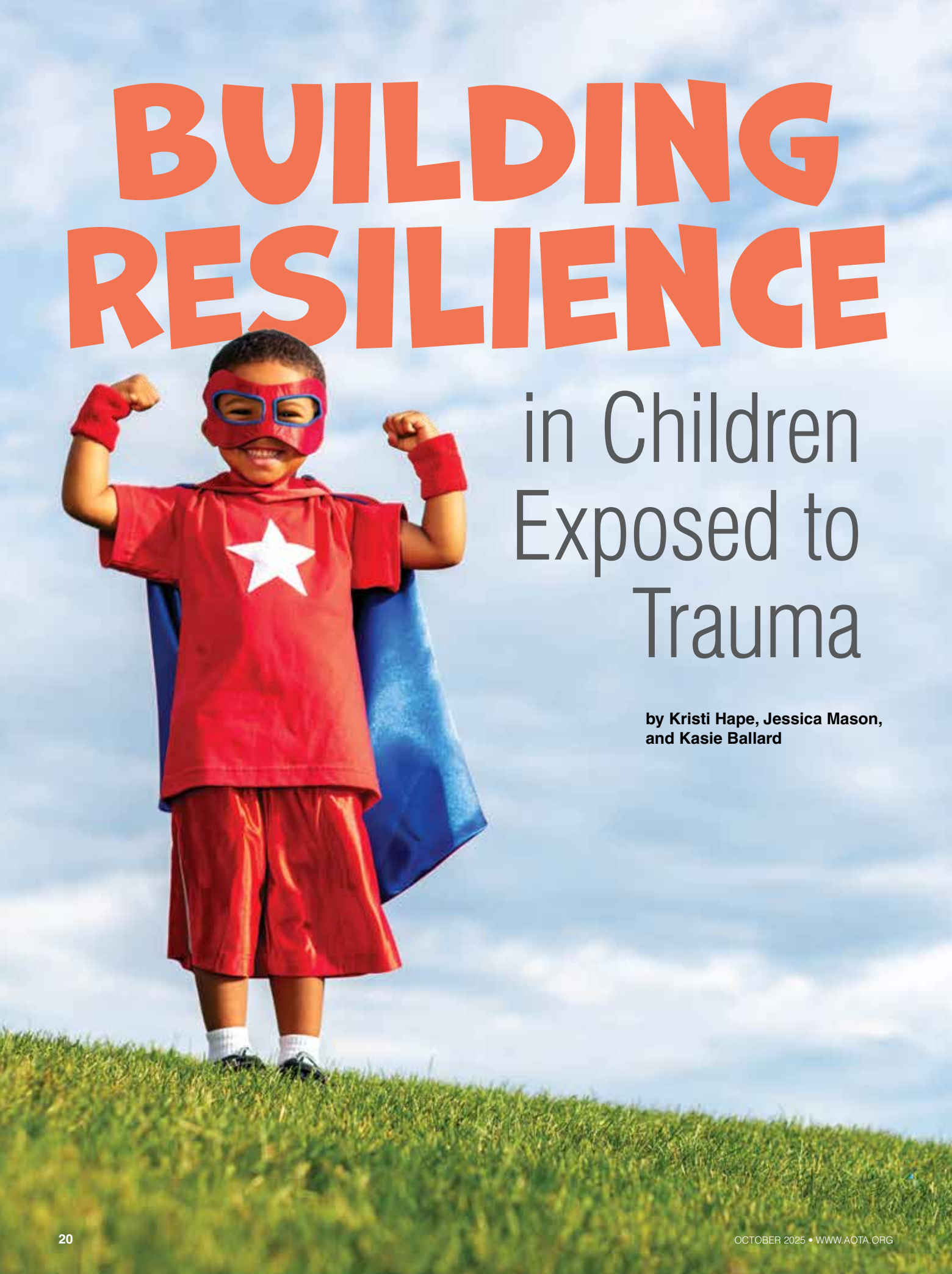
BUILDING RESILIENCE

in Children Exposed to Trauma

by Kristi Hape, Jessica Mason, and Kasie Ballard



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Trauma is defined as "an event or circumstance resulting in physical harm, emotional harm, and/or life-threatening harm" (Substance Abuse and Mental Health Services Administration, 2024, para. 1). Trauma experienced in childhood such as sexual, emotional, or physical abuse; exposure to natural disasters; or a witness to violence can lead to adverse childhood experiences (ACEs) (Lynch & Mahler, 2021). This article highlights the importance of a strengths-based and trauma-informed approach to emotional regulation in children with ACEs, offering strategies for occupational therapy practitioners (OTPs) to foster resilience, self-regulation, and posttraumatic growth in therapeutic settings.

Screening for ACEs

Emily Rothman and Amy Lynch (2023), recognized experts in trauma-informed care and occupational therapy, emphasized the importance of establishing a trauma-informed environment when working with clients and families affected by trauma. While many practitioners were screening clients related to their ACEs experiences, Rothman and Lynch (2023) offered a new evidence-based approach to this screening process. They advocated for the use of a positive childhood experiences (PCEs) screening tool, which assists OTs in identifying and supporting seven key PCEs that foster resilience and help buffer the effects of ACEs and trauma in the lives of children and families (Bethell et al., 2019; Rothman & Lynch, 2023;).

PCEs are an established protective factor against the negative effects of ACEs Baglivio & Wolff, 2020; Bethell et al., 2019; Daines et al., 2021; Hinojosa & Hinojosa, 2024; Samji et al., 2024). Research has suggested that individuals who have received supportive, nurturing, and positive experiences during childhood may be better equipped to cope with and overcome the challenges posed by ACEs and may reduce or eliminate the burden of illness related to the effects of ACEs when PCEs are present (Baglivio & Wolff, 2020; Bethell et al., 2019; Daines, et al., 2021; Hinojosa & Hinojosa, 2024; Samji et al., 2024). Research also has indicated that adults who report higher levels of PCEs demonstrate improved health and well-being as adults (Bethell et al., 2019; Crandall et al., 2019).

The seven PCEs include supportive relationships, a sense of belonging, and participation in joyful community traditions, all of which help foster resilience (Bethell et al., 2019). Using the PCEs screener encourages OTs to shift from a deficit-focused model to a strengths-based approach—one that emphasizes clients' inherent abilities and resources to support well-being and meaningful participation (Patten, 2022).

Screening for PCEs helps health care providers gain a holistic understanding of childhood experiences by identifying both adversity and sources of resilience (Rothman & Lynch, 2023). This strengths-based approach supports posttraumatic growth, highlighting the potential for positive psychological change following adversity. By identifying and fostering PCEs, OTPs help individuals build on their strengths, enhance coping mechanisms, and develop resilience

Table 1. Strategies to Foster Resilience and Self-Regulation Skills

Strategy	Action
Achieve self-regulation	• Educate children and families about self-regulation strategies, such as deep breathing, mindfulness, positive self-talk, problem-solving, and seeking social support. • Provide guidance on when and how to use these strategies effectively.
Create the just-right challenge	• Offer therapeutic challenges that are appropriately matched to the child's current skill level and ability to self-regulate. • Create opportunities to practice self-regulation strategies in a supportive and therapeutic environment to promote skill mastery and generalization.
Practice coping in the moment	• Encourage children and families to practice coping strategies in real-time when they encounter challenging situations. • Offer support and guidance as parents learn to model and practice these skills with their children.
Implement daily routines that support emotional regulation	• Help families establish consistent daily routines that incorporate activities and practices known to promote emotional regulation, such regular exercise, adequate sleep, healthy eating, and self-regulation techniques as a family.
Adapt to changing stress levels in life in child and family	• Recognize that stress levels can fluctuate during a period of time as a result of numerous factors, such as life events, school transitions, changing hormones, and external circumstances. • Provide ongoing support and guidance to help children and families adapt to these changes, adjust self-regulation strategies as needed, and build resilience in the face of adversity.
Develop a strengths-based approach	• Move away from a deficit-based approach, which involves reframing how OTPs perceive and interact with individuals with disabilities or challenges; instead of focusing solely on limitations or deficits, this approach emphasizes strengths, capabilities, and potential. By recognizing and building on clients' strengths and assets, OTPs can empower them to overcome barriers, achieve their goals, and lead fulfilling lives.

Note. OTPs = occupational therapy practitioners.

"IN THE THERAPIST–CHILD RELATIONSHIP, EMOTIONAL REGULATION SERVES AS A FOUNDATION FOR BUILDING TRUST, SAFETY, AND ATTACHMENT."

in the face of adversity (Baglivio & Wolff, 2020; Daines, et al., 2021; Hinojosa & Hinojosa, 2024; Samji et al., 2024).

Applying Therapeutic Use of Self and Therapeutic Alliance

OTPs' therapeutic approach plays a crucial role in supporting clients on their journey toward posttraumatic growth. Two key elements in this process are therapeutic use of self and a therapeutic alliance. *Therapeutic use of self* involves the deliberate and strategic use of our personal attributes, experiences, and responses to effectively engage with clients and promote positive outcomes, according to the *Occupational Therapy Practice Framework: Domain and Process, 4th edition* (American Occupational Therapy Association, 2020). The therapeutic alliance refers to the collaborative and mutually respectful relationship that develops between the OTP and the client (Babatunde et al., 2017). This alliance is characterized by open communication, trust, and shared goals—allowing for a safe space in which clients can explore their experiences, emotions, and aspirations (Babatunde et al., 2017).

Children who have experienced ACEs may struggle with managing their emotions because of past trauma, making it essential for practitioners to provide a supportive and nurturing environment in which children feel validated and understood. In the therapist–child relationship, emotional regulation serves as a foundation for building trust, safety, and attachment. Emotional regulation is a complex skill that develops over time and must be approached through a developmental lens. This means recognizing the stages of emotional development and tailoring interventions accordingly. Emotional regulation can be fostered through the following eight developmental stages:

1. Recognizing emotions in self
2. Recognizing emotions in others—Piaget's (1952) preoperational stage (see also Flavell, 1963)
3. Understanding emotional regulation using co-regulation from an adult
4. Recognizing dysregulation in self and others
5. Learning tools that support self-regulation (practicing when calm and regulated)
6. Applying tools that help regulate when dysregulated—Piaget's (1952)

concrete operations (see also Flavell, 1963)
7. Practicing self-regulation tools in natural environments
8. Generalizing self-regulation tools into daily occupations and environments—Piaget's (1952) formal operations (see also Flavell, 1963)

Shifting Traditional Therapeutic Approach to Trauma Treatment

As OTPs begin to approach treatment when trauma is present, we must change our traditional therapeutic approach and embrace the curiosity to grow empathy, creativity, and a deeper understanding of complex issues. By implementing the strategies listed in Table 1, practitioners can empower children and families to develop effective coping skills, build resilience, and adaptively respond to stress and challenges in their lives.

By implementing these strategies, OTPs and caregivers can empower children and families to develop effective coping skills, build resilience, and adaptively respond to stress and challenges in their lives. As OTPs, we can also consider the following four critical steps to change our approach to foster posttraumatic growth and resilience with the children and families we support:

1. **Build self-advocacy.** Building self-advocacy skills involves empowering individuals to speak up for their own needs, rights, and preferences based on their lived experiences. This can be achieved through education, skill-building, role-playing, and providing opportunities for individuals to practice assertiveness and self-expression.
2. **Be curious.** Adopting a curious mindset involves approaching situations with an open and inquisitive attitude by admitting that we have gaps in our knowledge and seeking to fill those gaps through exposure to innovative ideas (Brown, 2021). Curiosity can foster empathy, creativity, and a deeper understanding of complex issues (Brown, 2021). Adopting an attitude of curiosity encourages active listening, asking questions, and engaging in meaningful dialogue to promote learning and growth in our lives as well as the lives of our clients and families.
3. **Shift from a deficit-based approach.** Moving away from a deficit-based approach involves framing how we perceive and interact with individuals with disabilities or challenges. Instead of focusing solely on limitations or deficits, emphasize strengths, capabilities, and potential (Patten, 2022). By recognizing and building on clients' strengths and assets, we can empower them to overcome barriers, achieve their goals, and lead fulfilling lives (Patten, 2022).
4. **Use client strengths to push back against stressors.** By using their existing strengths, skills, and resources, clients can develop resilience and confidence and can master self-regulation strategies. Empowering clients to find ways to push back against stressors can foster the belief that they are able to navigate stress using their newly learned skills after discharge from therapy.

Changing Focus

By shifting the focus from problems to possibilities, practitioners help clients tap into their strengths, interests, and passions, paving the way for positive outcomes and meaningful engagement in daily life activities (Patten, 2022). Rather than focusing on the effects of trauma, OTPs can guide individuals toward their inner strengths, resilience, and self-regulation skills to support recovery and adaptation.

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Baby Hudson in a safe sleep position, sleeping in the NICU at CUMC-Bergan Mercy

Safe and Sound

Safe Sleep Practices for NICU Premature Infants

by Katelin Kearney, Lisa Bader, and Ryan Olson-Meyer

Sleep is an essential occupation, particularly for infants. It is imperative to promote a safe and positive sleep environment while infants' brains are rapidly developing (Edwards & Austin, 2016). Even just a few hours of sleep deprivation have been shown to create more challenges in an infant's development (Pittner et al., 2023). Sleep is especially vital for the neurodevelopment of preterm infants in the Neonatal Intensive Care Unit (NICU) because their brains are not yet mature (Park, 2020). Studies have shown the quality of an infant's sleep may be indicative of their physical, cognitive, and motor outcomes later in life (Park, 2020; Tham et al., 2017; Wang et al., 2024). On average, 3,600 infants in the United States die each year from sleep-related deaths (Goodstein et al., 2021). Occupational therapy practitioners (OTPs) can play an important role in assisting in sleep-related interventions for preterm infants.

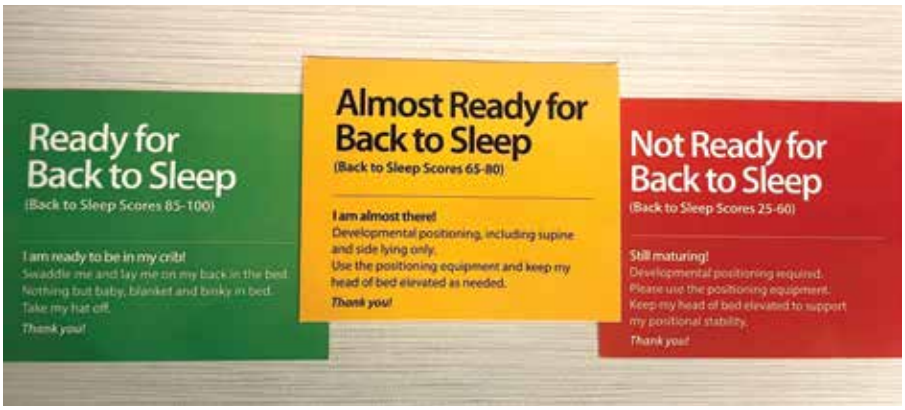
According to a 2021 clinical report, standardized sleep policies in NICUs are associated with higher rates of supine safe sleep (Goodstein et al., 2021). However, the same report acknowledged that NICU providers do not always support safe sleep for infants (Goodstein et al., 2021). Even though recommendations for safe sleep exist for infants in general, there are many fewer recommendations for infants in the NICU, leaving some to determine safe sleep practices for their particular clients. Many babies in the NICU require specific positioning devices for medical stability that can result in outliers of typical safe sleep practices. The American Academy of Pediatrics (AAP, 2023) has recommended that all hospitalized infants 32 gestational weeks or older be in the supine position to prepare for discharge, yet it has added that "not all infants will be clinically ready to be maintained in such a sleep environment at that age" (Goodstein et al., 2021, p. 17). This article describes a set of practices one hospital created to support safe infant sleep.

AAP's Recommendations on Safe Sleep

The AAP has recommended that infants be transitioned to safe sleep practices as soon as they are medically stable and well before their discharge date (Goodstein et al., 2021). The following are the AAP's safe sleep practices that specifically mention babies in the NICU (Goodstein et al., 2021):

- Emphasize the importance of human breast milk and its association with reducing the risk of sudden infant death syndrome (SIDS).
- Due to the risk of overheating, hats should only be used in the first hours of life or if an infant is in the NICU.
- Infants should be placed in the supine position during all sleep

PHOTOGRAPH BY KATELIN KEARNEY



Bedside "Back to Sleep" readiness cards.

while in the NICU when they are medically stable and have achieved positional stability, which typically occurs around 32 weeks gestational age.
- Parents of preterm infants should be educated on the importance of supine sleeping for the reduced risk of SIDS.

Committee Formation at CUMC-Bergan Mercy

Minimal recommendations exist that specifically address safe sleep for babies in the NICU. As a result, NICUs are left with the strenuous task of creating their own protocol for safe sleep practices. In an effort to increase safe sleep for premature and medically complex infants, CHI Health Creighton University Medical Center-Bergan Mercy Hospital (CUMC-Bergan Mercy) in Omaha, Nebraska, created a committee to establish guidelines for safe sleep practices in its NICU. The committee met formally four times during a 6-month period and set forth to create a policy statement and procedures for staff to follow.

Policy Statement Regarding Safe Sleep

CUMC-Bergan Mercy developed a policy statement on safe sleep practices at the facility. The goal was to create a safe environment for infants during their critical occupation of sleep while following research and considering prematurity, and medical and positional instability. The statement specifies the following:

- Parents will be educated regarding the recommendations set forth by the National Institutes of Health and the AAP.
- Staff will serve as role models and will encourage parents to follow these guidelines while in the hospital and at home.
- Staff will demonstrate appropriate positioning and provide education if they observe parents or staff not following safe sleep guidelines.
- Staff will complete yearly education on safe sleep principles.

CUMC-Bergan Mercy's Back-to-Sleep Procedures

CUMC-Bergan Mercy created its own back-to-sleep initiative; the back-to-sleep practices are to be used for every infant unless an outlier exists. Staff at the facility adhere to these following safe sleep practices:

- The Back to Sleep Protocol Readiness Assessment (based on Als, 1982, and adapted by Hofherr, 2007), helps determine whether the baby is medically stable enough for the head of the bed to be flat whether in the isolette or open crib. This assessment is administered weekly to every baby at 33 weeks gestational age unless medically unstable and can be administered by the OTP, registered nurse; or, preferably, as a collaborative assessment.
- The assessment looks at the following characteristics in the newborn infant:
  - State: stability of state
  - Motor: posture/tone stability
  - Autonomic: vital sign changes, visceral and color responses during cares
  - Regulation: response to support
  - Respiratory support
- The head of bed is to be flat and the infant in supine position if the infant scores 85 out of 100 or more on the Back to Sleep Protocol Readiness Assessment and is at least 33 gestational weeks old.
- Newborns with nasogastric or orogastric feeding tubes do not need to have the head of bed elevated.
- Nothing should remain in the baby's open crib other than a pacifier. The pacifier should be placed directly in the crib—not in a cup.

Although not formally written, CUMC-Bergan Mercy does not allow babies in the NICU to wear hats—despite the AAPs statement—which helps ensure that infants are ready for back to sleep in the supine position while maintaining their temperature. Hats should not be worn during sleep at home.

Outliers

Even with these practices at CUMC-Bergan Mercy, outliers can exist as a result of each infant's unique needs. The Back to Sleep Protocol Readiness Assessment should not be completed—regardless of age—if the infant

- is in isolation,
- is intubated or is on 4 or more liters of Vapotherm®,
- has IVs, or
- was recently circumcised.

The following outliers require medical orders.

- If the infant scores an 85 out of 100 or more on the Back to Sleep Protocol Readiness Assessment and needs to be positioned in a nonsupine position to accommodate individual clinical needs (i.e., excessive apnea/bradycardia events, excessive emesis/reflux).
- If the infant scores an 85 out of 100 or more on the Back to Sleep Protocol Readiness Assessment and the head of bed needs to remain elevated for medical reasons.
- If the infant scores higher than 85 out of 100 on the Back to Sleep Protocol Readiness Assessment and the head of bed is flat but items such as orthopedic positioning or head-shaping devices, are issued

PHOTOGRAPH BY KATELIN KEARNEY

Figure 1. Sample Back-to-Sleep Protocol Monitoring of Babies

DATE	CORRECT (HOB Flat)	ELEVATED (BTSA Documented)	ISSUES/CONFUSION	N/A	Number of Babies
6/14/23	16=44%	7=20%	3=8%	10=28%	36

Note. HOB = head of bed; BTSA = best time for sleep awakening; N/A = not applicable.

by occupational therapy; these devices may remain in the crib longer than 33 gestational weeks; preventing head shape deformities is an important task of neonatal therapists (Craig & Smith, 2020). If these devices are in place and the infant's feedings are moved to an ad lib on demand schedule, the devices should be removed 3 days before discharge to model safe sleep practices at home.

Results and Auditing at CUMC-Bergan Mercy

Occupational therapy, as part of the back-to-sleep committee, completed weekly audits for 6 weeks, starting 2 weeks after the new back-to-sleep initiative began. Before the initiative at CUMC-Bergan Mercy, most heads of beds remained elevated for many weeks in the open crib. Therefore, this truly was a new initiative for the NICU. Babies were audited weekly, and most weeks looked like the one shown in Figure 1.

Typically, for about 1% to 8% of infants, confusion existed about whether the head of bed should be elevated, or documentation for the head of bed to be elevated was incorrect. During the 6 weeks, the issues and confusion portion of the audit became 0% to 1%, and audits were no longer needed. Occupational therapy, however, continues weekly checks on all babies to ensure the protocol is being followed and that the Back to Sleep Protocol Assessment is being completed.

Conclusion

A positive and safe sleep environment is essential for an infant's development. Considering the prematurity, positional instability, and medical complexity of infants admitted to the NICU, it can be difficult for hospitals to determine the best course of action when it comes to sleep. Although general practices advise placing infants on their back for every sleep from birth, this position is not always attainable for infants requiring more support. Although it is recommended that nothing be in the crib with an infant, necessary positional devices are considered appropriate in certain instances.

CUMC-Bergan Mercy's committee came together to create foundational safe sleep practices in the facility's NICU. The protocol formed sought to educate parents and staff on the established practices. It was determined that the Back to Sleep Protocol Readiness Assessment is to be administered weekly to every baby, unless contraindicated, at 33 weeks gestational age. This assessment helps determine whether infants are ready for back-to-sleep practices based on medical and positional stability. When infants score 85 or more out of 100, they are to be placed in the supine position with the head of the bed flat and nothing but a pacifier in the open crib.

With the unique fragility of NICU infants, outliers do exist. Orders must be received for infants who are at least 33 gestational weeks and scored 85 or more out of 100 to elevate the head of the bed or to be placed in a nonsupine position.

Because of current gaps in knowledge, more research and education are needed regarding safe sleep practices for premature and medically complex infants in the NICU. OTPs play an important role in carrying out current practices and educating parents on the importance of safe sleep to reduce the risk of SIDS. CUMC-Bergan Mercy demonstrated a commitment to developing specialized safe sleep practices for babies in their NICU to ensure that infants sleep safely and soundly.

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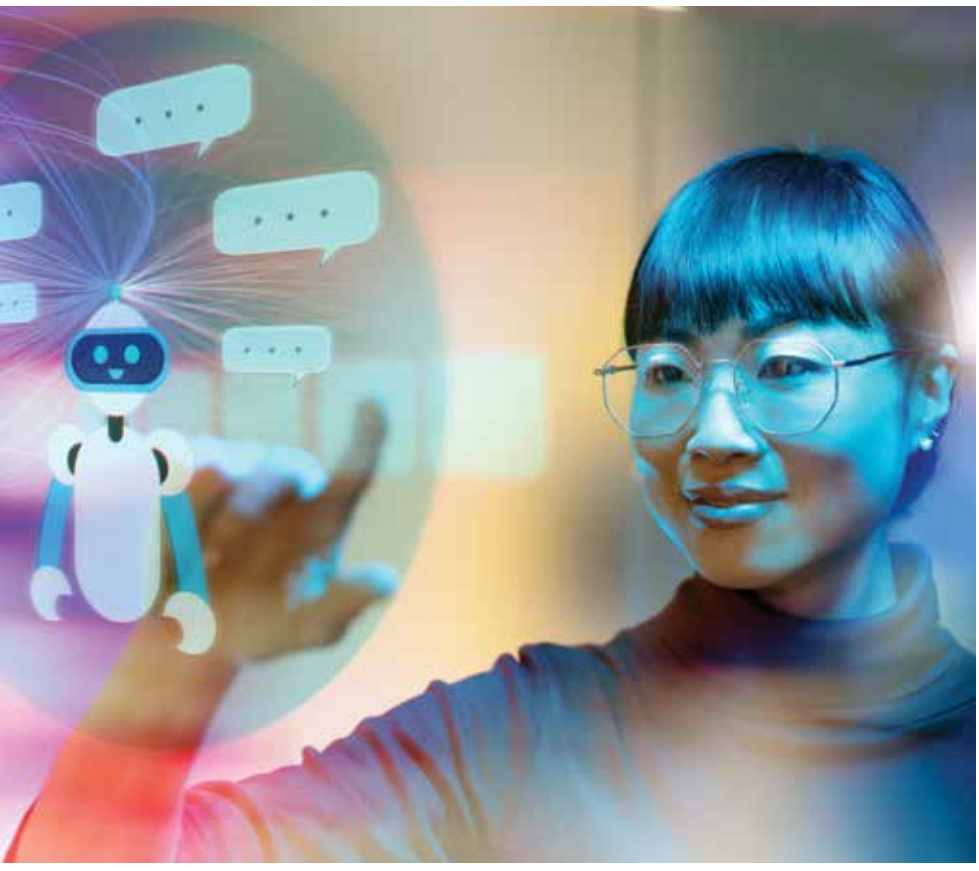
Future Proofing OTPs:
Preparing for Workplace AI Integration

Gabrielle Gelfen

Artificial intelligence (AI) is rapidly transforming health care by streamlining administrative tasks, enhancing diagnostic accuracy, and accelerating access to medical data (Davenport & Kalakota, 2019). AI systems can quickly process large volumes of health care information and hold the promise to reduce costs, improve client experiences, and support evidence-based decision-making (Chen & Decary, 2020). AI has tremendous potential to assist health care teams in developing innovative treatments, educating clients, coordinating care, supporting clinical decision-making, supporting research, and tailoring treatment plans (Chen & Decary, 2020; Koteluk et al., 2021; Liu, 2018; Reynolds, 2023). For occupational therapy practitioners (OTPs) who are known for innovation and client-centered care, AI presents both opportunities and challenges. As AI tools become more available to clients, OTPs need to be equipped to support, evaluate, and collaborate with clients who incorporate AI-generated health information into their care.



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Supporting Clients Who Consult AI

Access to credible health information empowers clients to advocate for their health and take a proactive role in their own health and wellness. Rather than questioning whether clients should consult AI, it is more productive to ask how OTPs can best support clients who do. A recent study found that 89% of clients use search engines before contacting a physician (Ayoub et al., 2023). Generative AI platforms like ChatGPT and Google's Gemini offer quick, tailored answers that can influence how clients understand their diagnoses, treatments options, and rehabilitation goals. Because generative tools are increasingly used in place of traditional search engines, it is important to understand the limitations of AI and become familiar with its potential as well as maintain a critical perspective of AI-generated output.

The challenge is not whether clients should consult AI, but how OTPs can meet clients where they are with AI. For example, if a client comes to a session and states, "ChatGPT said I should try mirror therapy for my stroke recovery," the OTP has a chance to validate the client's initiative while also guiding the discussion towards evidence-based case. In such cases, OTPs might respond by asking where the information came from, explaining whether mirror therapy aligns with the client's specific needs, and offering education on

how treatment decisions are made collaboratively. This approach honors client autonomy while positioning the OTP as a trusted partner who can differentiate between general AI recommendations and individualized care.

Concerns With AI in Health Care

Many generative AI systems are designed to produce outputs that appear clear and direct, leading some users to trust them more than search engine results (Leveridge, 2023). However, overconfidence in AI-based results can be problematic. AI-generated responses can include factual errors or hallucinations in which content is created without a factual basis (van Dis et al., 2023). Bias in technology, including AI-based systems, can arise from the programming, the data used to train the models, or inadequate oversight and safeguards (Howell et al., 2024; Richardson et al., 2022). AI algorithms may not identify whether sufficient data exist for a rare medical condition, may provide outdated information, or may not inform users of these limitations (Sandmann et al., 2024; Watcher & Brynjolfsson, 2024).

These risks are particularly concerning within occupational therapy, a field in which individualized, evidence-based interventions are essential. OTPs must be vigilant in verifying AI outputs and guiding clients toward reliable sources of care. A foundational understanding of how AI works will empower OTPs to evaluate and communicate the relevance of AI-generated content within the therapeutic process.

Viewing AI as an OTP's Tool

Generative AI holds the promise for enhancing care and client engagement in occupational therapy. Careful consideration of the current limitations of AI-based systems, and sharing these with clients as necessary, is needed. OTPs can play a key role in guiding clients through the responsible use of AI and advocating for AI-based systems that avoid introducing new disparities (American Occupational Therapy Association [AOTA], 2020; Richardson et al., 2022).

Teaching Clients to Assess AI Information

OTPs can also take on the role of educator by helping clients critically evaluate the AI-generated information they bring to therapy. Many clients do not realize that AI tools may omit sources or reference non-peer review material. For example, if a client presents a summary of treatment options from ChatGPT, the OTP might ask, "Did you look at the links or original sources it mentioned?" This can prompt a conversation about why reviewing the full source matters and how clients can better assess the credibility of online health content.

Where appropriate, OTPs can coach clients by doing the following.

- Look for original citations or scientific studies. Many clients assume AI is authoritative, prompting them to look for original sources teach healthy skepticism.
- Compare AI-generated suggestions to clinician-recommended practices by reviewing the AI-generated content with the client during a session. This method can assist with generalizations or with pointing out inconsistencies.
- Bookmark trusted sources, such as academic journals or official therapy associations (Mayo Clinic, The National Institute of Health [NIH], AOTA, etc.) and provide printed or digital handouts. This can channel curiosity toward vetted resources and build digital literacy skills.
- Educate clients on the limitations of AI responses by clarifying that AI provides the average response based on the information that is located. This may not align with the particular client, especially for rare or infrequently written conditions.
- Help clarify that AI is not a replacement for clinical expertise and set boundaries around AI in care. OTPs can state, "AI tools are helpful for learning, but we'll always base your care on your specific needs, safety, and progress."

By helping clients become informed consumers of AI, OTPs reinforce client-centered care while strengthening clinical rapport.

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The Role of Occupational Therapy in Treating Seasonal Affective Disorder

Amy Hudkins

Kerri Golden

Seasonal affective disorder (SAD) is a subtype of depression that occurs seasonally, typically in the fall and winter months. It can affect an individual's well-being, ultimately resulting in a disruption of occupational engagement and performance. Occupational therapy plays a significant role in addressing SAD by fostering meaningful activities, enhancing daily routines, and integrating environmental modifications. This article explores the role of occupational therapy in managing SAD with interventions grounded in the *Occupational Therapy Practice Framework: Domain and Process, 4th edition* (*OTPF-4*; American Occupational Therapy Association [AOTA], 2020) that focus on improving client outcomes.

Incorporating light therapy into a morning routine is a convenient way to ensure early day exposure to brighter light.

PHOTOGRAPH BY MITCHELL JUBAS

SAD is characterized by recurrent depressive episodes coinciding with seasonal changes, primarily during periods of reduced sunlight. Its symptoms include fatigue, hypersomnia, irritability, and diminished interest in activities (American Psychiatric Association, 2022). Occupational therapy practitioners (OTPs) working in a wide variety of settings may observe clients exhibiting symptoms of SAD, and although a formal consultation with a health care provider may be recommended, OTPs are fully equipped to make suggestions for practical lifestyle changes and environmental modifications to help mitigate the symptoms associated with SAD. Pharmacological treatments like antidepressants and psychotherapy are commonly indicated; however, incorporating occupational therapy approaches provides a client-centered approach to managing this condition and restoring quality to engagement in occupation.

OTPs can address SAD by fostering adaptive behaviors, creating individualized intervention plans, and encouraging meaningful engagement in daily activities. Training and skills in the areas of activity analysis, occupational assessment, environmental assessment, psychosocial practice, and client-centered care support OTPs to be included in addressing this condition, whether it accompanies a co-occurring diagnosis or not. This article examines evidence-based occupational therapy interventions for SAD, emphasizing structured routines, activity modifications, and environmental adaptations informed by the *OTPF-4*.

Interventions in Occupational Therapy for SAD

Light Therapy Integration

Exposure to bright light therapy is a primary treatment for SAD (Rohan et al., 2015). Occupational therapists (OTs) can

facilitate the integration of light therapy into clients' daily routines, ensuring adherence and maximizing effectiveness. Recommendations may include using lightboxes during morning routines or creating well-lit environments to mimic natural daylight. Research suggests that light therapy be implemented in the morning, preferably before 8:00 am, for a minimum of 30 minutes, and on a consistent basis (Levitan, 2005). Likewise, research supports avoiding bright light and blue spectrum light in the evening and before sleep (Murray et al., 2021). A practical suggestion is to use a lightbox, such as the Verilux® HappyLight (see Figure 1), in the bathroom during a morning shower, in the kitchen as one prepares and eats breakfast, or while reading. All precautions should be taken and discussed with a health care provider if an individual has photosensitivity.

Figure 1: Verilux HappyLight

Activity Scheduling and Routine Building

The *OTPF-4* emphasizes the role of "habits, routines, and roles" in occupational performance (AOTA, 2020, p. 7). Disrupted routines can exacerbate depressive symptoms in SAD, and, coincidently, SAD can disrupt engagement in regular routines and habits, causing a cyclical negative effect on performance and quality of occupational engagement. Maintaining a daily schedule can assist in maintaining stable moods (Murray et al., 2021). Occupational therapy interventions include creating structured daily schedules that balance rest and activity. Using the concepts of activity analysis, OTPs can assist clients in grading and adapting daily activities that best match their occupational profile and values during the winter season. Interventions can include making a daily list of to-do items, prioritizing necessary ADLs, or using an app or phone alarms to assist in organizing daily routines.

Ensuring a consistent routine that includes physical activity, social interaction, ADLs, and pleasurable activities can mitigate the feelings brought on by SAD (Murray et al., 2021). An OTP may suggest integrating energy conservation techniques if clients feel unmotivated or overwhelmed by engaging in typical daily activities on a regular or needed basis. For example, if meal planning and preparation are affected by symptoms of SAD, exploration of easier solutions, such as crockpot or microwave meals, may both meet the needs of the client and provide relief of the stress this occupation may cause.

Environmental Modifications

Physical and social environments contribute to occupational performance (AOTA, 2020). Environmental factors include the physical, social, and attitudinal surroundings in which people engage in valued occupations (AOTA, 2020). Modifying environments to optimize natural light exposure and enhance mood is a key occupational therapy strategy. Therapists may suggest rearranging living or workspaces to maximize natural and artificial light exposure; using daylight simulation bulbs; or incorporating calming design elements, such as mood-enhancing colors and textures (Langer, 2023). Rearranging furniture to be closer to windows and natural light as well as ensuring blinds and curtains are open during the brighter parts of the day assist in adhering to natural light cycles (Langer, 2023).

Cognitive–Behavioral Strategies and Coping Skills

Cognitive–behavioral strategies integrated with occupational therapy sessions address maladaptive thought patterns associated with SAD. Guided by the process of fostering performance patterns, interventions like gratitude journaling and mindfulness exercises help clients manage stress and negative thoughts (Komase et al., 2021).

Gratitude journaling is a way of keeping track of things that promote grateful mindsets and decrease stress and worry. Gratitude journals have proven to be effective in improving mental well-being (Emmons & McCollough, 2003). Journaling is a practical intervention to include during an occupational therapy session and could consist of listing a specific number of things clients are grateful for (currently or in the past), listing some thoughts that produce a sense of joy, identifying others who are appreciated and why, and what someone looks forward to each day (Komase et al., 2021). In addition, a referral may be necessary to other health care professionals for interventions like cognitive–behavioral therapy and, in some cases, antidepressants (Melrose, 2015).

Occupational Engagement and Physical Activity

Physical activity and engaging in meaningful occupations are the basis of occupational therapy (AOTA, 2020). Valued activities such as volunteering, participating in creative arts, or being involved in the community can mitigate SAD symptoms by fostering a sense of purpose and connection. Although some may find a reduction of interest in valued leisure activities when SAD symptoms

Simple environmental modification, such as relocation to a well-lit area, may assist in mimicking dependency on natural light cycles.

are persistent, OTPs can analyze these activities to assess the best time of day to implement, assess motivation tactics to engage, or grade the activity to make it more manageable for the client.

Physical activity is known to stimulate three main neurotransmitters: dopamine, norepinephrine, and serotonin (Lin et al., 2013). These neurotransmitters provide feelings of pleasure, satisfaction, and increased mood. Although any type of exercise appears to be beneficial, combining it with a social component (e.g., having an exercise partner or participating in group exercise classes) enhances the benefits exercise has on mood (Drew et al., 2021). Therapists can collaborate with clients to develop tailored activity plans that reflect their personal interests and goals, whether following a regimented exercise schedule or simply incorporating extra walking into daily routines, such as strategic parking that will require extra walking or setting a daily step goal to achieve.

Conclusion

Occupational therapy focuses on quality of life, well-being, and occupational performance. Addressing the needs of clients experiencing SAD via occupational therapy interventions can improve or enhance engagement in occupation and result in positive outcomes. Empowering individuals to engage in simple activities and alterations like those described in this article can support a rich quality of life, a full sense of well-being, and increased interest and engagement in daily occupations all year round.

Occupational therapy offers a comprehensive, client-centered approach to managing SAD. Occupational therapy interventions address the interplay of environmental, emotional, and occupational factors. By incorporating evidence-based strategies, OTs enable clients to regain control of their lives during challenging seasonal transitions. Future research should explore the long-term benefits of occupational therapy in SAD management, emphasizing collaboration with other health care disciplines.

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PHOTOGRAPH BY MITCHELL JUBAS

From Scrolling to Stitching:
Returning to Our Arts and Crafts Roots

Marla Davis

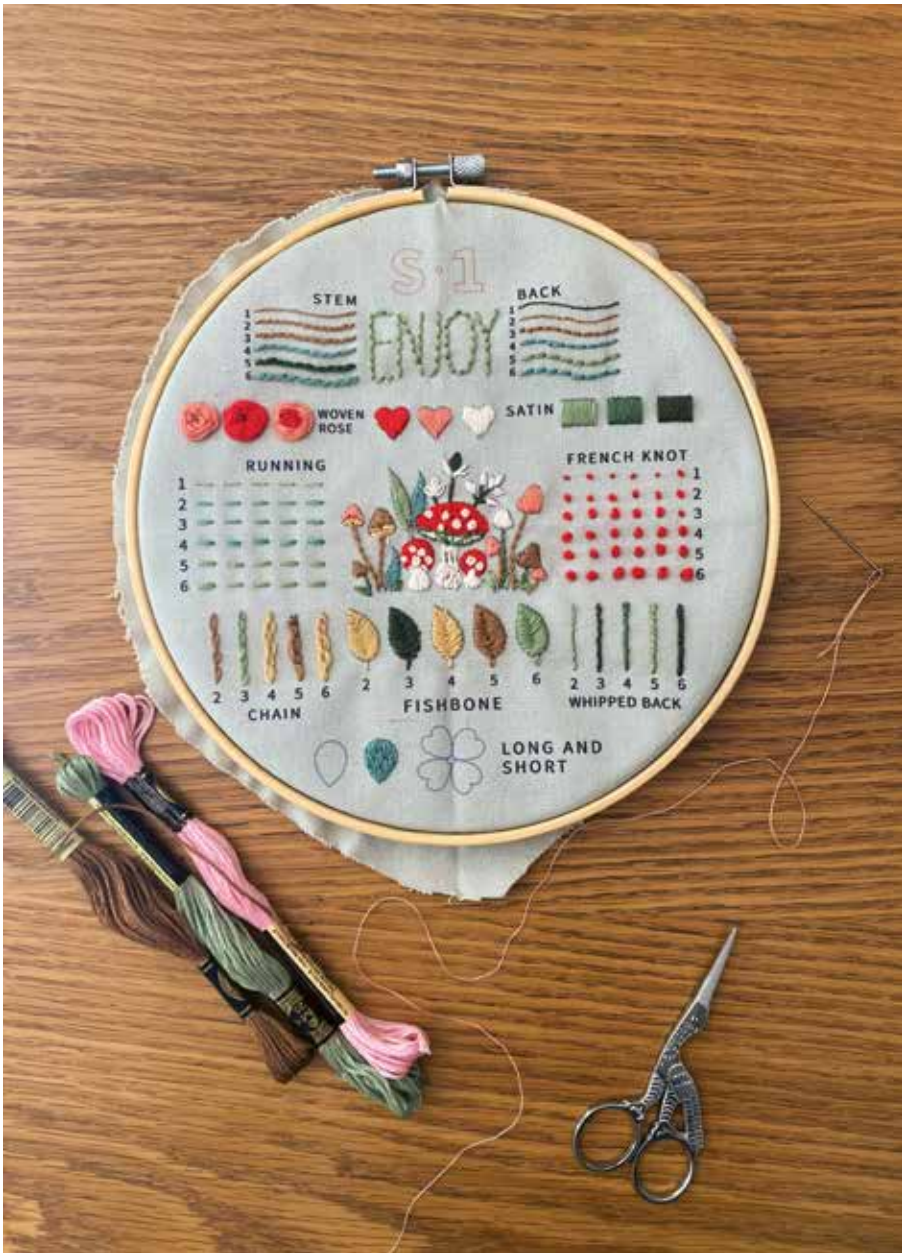
PHOTOGRAPH BY MARLA DAVIS

My first completed project: A custom portrait of my dog.

Although the purpose of this article is not to analyze the influence of the Arts and Crafts Movement on occupational therapy, it is important to understand its overall effect to orient the reader. Before the formal inception of occupational therapy in 1917, key movements and ideas were shaping the social landscape; priming the soil that would eventually sprout and grow our profession. One such movement was the Arts and Crafts Movement. To understand the importance of this movement, let's rewind slightly to the industrial revolution.

A time of immense progress with the use of machinery, factory work, and mass production of goods, the industrial revolution was perceived by some as a threat to the innermost part of humankind. Until this point, many goods were produced by hand with the creator taking pride in their work and accomplishment. In an effort to keep arts and crafts alive, the Arts and Crafts Movement was born. Situated in the mid- to late-1800s, the premise of the Arts and Crafts Movement was that the increased use of machinery could take away valuable skills that humans possessed, which were often a source of pride, accomplishment, and income. The originators believed that "the action of making handmade goods integrated the mind and body, providing intrinsic satisfaction to the craftsman" (Andersen & Reed, 2017, p. 9).

Spreading from its roots in Europe to the United States, Hull House, part of the Settlement House Movement, became the meeting space for the Chicago Arts and Crafts Society. Members of Hull House sought to recreate "the ideal of the craftsperson," although society members lived in the machine age (Quiroga, 1995, p. 39). The influence of this movement can be seen in the early years of our profession, which used arts and crafts as a primary tool



A sampler was a helpful way to learn and practice new stitches.

PHOTOGRAPH BY MARLA DAVIS

for intervention, sometimes referred to as occupations that are curative (Quiroga, 1995). Evidence of this can be seen in early photographs and articles related to the profession, many occurring during World War I.

Even as the profession began to move toward a medical model in the mid-1900s, evidence of our roots was still present. In the early editions of *Principles of Occupational Therapy*, chapters on "Activities in Occupational Therapy" included arts and crafts (described as handcrafts), such as weaving, freehand drawing and lettering, jewelry making, and carving (Edgerton, 1954). These activities were described as *diversional*, meant to divert thoughts and to constructively use leisure or recuperation time. The introduction to this specific chapter made sure to note that occupational therapy is more than just crafting, and various activities were described, including their therapeutic application and value (Edgerton, 1954).

As our profession progressed, arts and crafts decreased as the primary intervention method for our clients. Fast forward to the present day: Arts and crafts still play a role in society at large, and this role may even be increasing. The rise of Pinterest in the 2010s sparked many to create with groups of friends gathering for painting or craft nights (Weston, 2023). Similarly, although not a typical arts and crafts activity, the trend of making sourdough bread from scratch has increased. The author of one article even noted the welcome distraction it created from their phone (McCarthy, 2024), the common thread being engagement in the process of making something.

It may be, as Levine (1987) noted, a resurgence of—or perhaps a renewed focus on—an innate need to build a slow-paced, meaningful life. The Arts and Crafts Movement could certainly experience a revival, reinvented to serve as an antidote to the immense effect of technology on our world. In reading one of the seminal works of our profession, I came across this quote and wondered what would happen if we changed *mechanized* to *technologized*: "In an age that is becoming increasingly mechanized, it is a healthy thing to retain the time-honored hand skills for their value in mental hygiene and as hobbies, if for no other reason" (Edgerton, 1954, p. 48).

Case Example: Reflection on My Own Experience

When I took inventory of my personal life, prompted by a screen time notification on my phone, I realized I was occupying much of my time with social media use, scrolling time away. This phenomenon, often described as *doomscrolling*, was something that I noticed occurring when my hands were not occupied, such as on long drives or while watching television (Hernández, 2022). Having just taught a unit on the history of our profession, digging into our roots in the Arts and Crafts Movement and use of handcrafts as a therapeutic activity, I wondered if the founding members' use of arts and crafts as curative occupations was still applicable today. I had long been fascinated with our profession's early focus on occupying the hands, which, in turn, was thought to occupy the mind. This concept was seen in many early writings, including Meyer's 1922 *Philosophy of Occupational Therapy* in which he noted that activities, such as handwork, weaving, or basketwork, could bring "a pleasure in achievement, a real pleasure in the use and activity of one's hands

and muscles and a happy appreciation of time" (p. 3).

As I was searching on social media, quite ironically, I came across an embroidery kit that caught my eye. Although I do enjoy crafting and engaging in small projects, I was yearning for something that could become more of a lifelong pursuit and not just a one-time project. The second edition of *Principles of Occupational Therapy* categorized needlework (which mentioned embroidery) as a "Handcraft," noting that it meets the criteria for successful use in occupational therapy (Edgerton, 1954). I felt it would pay homage to our profession's roots while fulfilling the purpose of my personal exploration. The aim of this exploration was to determine if stitching could serve as a meaningful occupation to engage in, by occupying my hands with a craft and negating the emotional toll of doomscrolling.

Personal Experience and Reflection

After obtaining all of the supplies and purchasing a beginning kit where I could learn the basic stitches, I began my journey. At first, I was unsure when I would learn a whole new craft among my many other commitments. Using my occupational therapy skill set, I assessed my daily routine and noted that I used my phone most during the evening after I had completed my tasks for that day. Because I wanted to specifically use embroidery in place of my phone (e.g., scrolling on social media), I planned to work on embroidery in the evening. The first few days were filled with the attention and focus demanded by learning a new, novel motor activity.

When I became confident in a few stitches, such as a backstitch or stem stitch, I began to enter a flow state spurred on by the methodical and rhythmic movement of the stitching. Similar to the observations made in the early years of our profession, I found that completing a certain stitch or image on my embroidery hoop gave me a sense of pride, accomplishment, and achievement (Meyer, 1922), something that scrolling on my phone did not. I would show my friends and family my completed projects. In addition, I saw my phone use decreasing, supported quantitatively by the decreasing screen time percentage, and noticed that my overall well-being and mental health were supported, likely because I was no longer spending long periods of time doomscrolling. I certainly noticed how working with my hands felt different than other activities, a different sense of accomplishment and self-worth. This sentiment is espoused by Elizabeth Yerxa (1980): "By developing skills in the use of one's hands and raw materials, a person can revive a sense of competency and be re-connected with the natural environment, thus finding new purpose and meaning in self-initiated activity" (p. 533).

Lessons Learned

Only time will tell if embroidery and needlework will become embedded in my routine as a truly meaningful occupation in the years ahead. Although my personal study and exploration ran for approximately 3 months, I did glean some overarching lessons and takeaways:

- I found that projects with a purpose led to greater internal motivation to complete them—for example, embroidering a hat to give as a gift to a family member.
- The rhythmic and methodical movements of stitching helped me to slow down and enter into a flow state, minimizing the time I was spending on social media, thus supporting overall mental wellness for myself.
- Learning a completely new task challenged various performance skills, such as process skills and motor skills. It served as a gentle reminder to give my clients grace when they are learning a new task.

Applications for Practice

Although this represents one perspective and experience, I ventured to draw a few broad applications for occupational therapy practitioners (OTPs):

- OTPs may consider exploring and incorporating handcrafts with clients to reengage with leisure occupations and support a variety of outcomes, using grading, adapting, and scaffolding in the learning process.
- OTPs may consider how engaging in handcrafts may support their own overall mental health, specifically for burnout.
- Our unique domain is our focus on engagement in meaningful occupation. Although some may consider handcrafts or crafting a "simple" activity, I would encourage OTPs not to underestimate the power and meaning that a seemingly simple activity may hold.

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Continuing Education Opportunities

Everyday Ethics: Core Knowledge for Occupational Therapy Practitioners and Educators, 4th Edition by Deborah Yarett Slater, OT, MSOT, FAOTA. This important CE course provides an overview of key ethical theories, the Occupational Therapy Code of Ethics and Standards of Conduct, a Framework for Ethical Decision Making with case analysis and the role and function of agencies which regulate the occupational therapy profession. Earn .2 AOTA CEUs (2.5 NBCOT PDUs/2 Contact Hours). Order #OL4953

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AJOT CE: What If Deliberately Dying Is an Occupation? This article aims to open a dialogue within the field of occupational science and occupational therapy about this sensitive and potentially controversial issue. Earn .1 AOTA CEUs (1.25 NBCOT PDUs/1 Contact Hour). Order #CEAJOT121

Addressing Sexuality with Community Dwelling Older Adults by Keeley Cowley, OTD/S. This course will serve as an introduction to understanding the importance of sexuality for older adults, the impact of the natural aging process, and how individual practitioners can address sexuality- related concerns within practice. Earn .1 AOTA CEUs (1.25 NBCOT PDUs/1 Contact Hour). Order #OL8372

3D Printing Adaptive Equipment for Individuals with Arthritis or Rheumatic Conditions by Elizabeth Fain, EdD OTR/L and Jeff Powell, MS. This course offers an overview of arthritis and the impacts it has on occupations as well an overview of 3-D printing process from beginning to end. Earn .1 AOTA CEU (1.25 NBCOT PDU/1 contact hour). Order #OL8306.

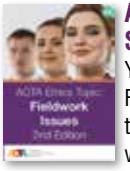
Addressing Social Determinants of Health in Occupational Therapy Service by Sierra Clair, Dr.OT, OTR. In order to successfully address clients' social determinants of health, practitioners must first recognize their impacts on daily practice and determine which of the various levels within OT practice offers the best solution. This course will serve as an introduction to understanding social determinants of health, their impacts on clients, and how individual practitioners can address them on micro, meso, and macro levels. Earn .1 AOTA CEUs (1.25 NBCOT PDUs/1 Contact Hour). Order #OL8320

Occupational Therapy's Role in Addressing Sexuality and Intimacy by Tiffany Lee, OTD, and Jacqueline Marquez, OTD. The topic of sexuality and intimacy is often under-addressed by health care professionals, despite its importance to clients. According to the Occupational Therapy Practice Framework, engagement in sexual activity is not only an ADL, but can be a key aspect of social participation in the context of familial and peer/ friend roles. The purpose of this course is to provide an opportunity for OT practitioners to increase their knowledge and confidence when advocating for an occupation that is often overlooked. Earn: .1 AOTA CEU (1.25 NBCOT PDU/ 1 Contact Hour). Order #OL5165.

Occupational Therapy in the Inpatient Rehabilitation Setting for Patients with COVID-19 by Melissa R Brottman, OTD, OTR/L, CPAM, et al. This course highlights effective interventions and assessments and will help you to understand the importance of a team approach to rehabilitation, how to start a COVID program, and various special considerations for patients continuing to recover from this disease. Earn: .15 AOTA CEU (1.88 NBCOT PDUs/1.5 Contact Hours). Order #OL8309.

Occupational Therapy's Role in Trauma-Informed Schools by Sharon M. McCloskey, EdD, MBA, OT/L, CTP; Meghan Suman, OTD, OTR/L, BCP, SCSS. The purpose of this course is to familiarize you with the typical response to trauma in the brain, and sequelae of experiences and behaviors that can occur when the thinking brain is deactivated, and the emotion brain takes the lead in response to future perceived threats. Also discussed is the need to address trauma through the inclusion of trauma-informed approaches within the school and school system. Earn .1 AOTA CEU (1 contact hour; 1.25 NBCOT PDU) Order #OL8376.

Assistive Technology, Universal Design for Learning, and School-Based Practice by Pamela Stephenson, OTD, OTR/L, BCP, FAOTA; Mindy Garfinkel, OTD, OTR/L, ATP. This course provides a foundational understanding and definition of assistive technology and universal design for learning. Information on how these can be embedded into school-based practice is also provided. In addition, the course outlines the role of legislation in supporting the use of technology in school contexts. Earn .15 AOTA CEUs (1.5 contact hours/1.88 NBCOT PDUs). Order #OL8408.



AOTA Fieldwork Ethics, Second Edition by Deborah Yarett Slater, MS, OT/L, FAOTA. For most of us, there will come a time in our professional career when we will either work alongside or supervise fieldwork students. Awareness of ethical issues that may arise in these situations and thoughtful ways to analyze and resolve them is an important skill. This online course provides helpful information on fieldwork ethics to the student, fieldwork educator, and academic fieldwork coordinator. This course is appropriate for clinical fieldwork educators, academic fieldwork coordinators and occupational therapy and occupational therapy assistant students. Earn .15 AOTA CEU (NBCOT 1.88 PDUs/1.5 Contact) Order #OL8400

Performing a Home Health Start of Care Course Bundle. by Karen Vance, OTR/L and Carol Siebert, OTD, OT/L, FAOTA. This course bundle will provide you with important information needed during the start of care process. Topics covered include the importance of starting care for OTs; changing the perception of occupational therapy in the home care community; changes to legislation; and the medication reconcilliation process—in addition to others. Individuals completing the series including three 'Essentials' courses are eligible to receive the AOTA Performing a Home Health Start of Care micro credential and digital badge. Please see the Performing a Home Health Start of Care digital badge page for more information about requirements for obtaining the micro credentials. Earn .85 CEUs (8.5 NBCOT PDUs/10.5 Contact Hours). Order #OL8334. Total Bundle Credit: AOTA Members: $189.65, Nonmembers: $259.65. http://store.aota.org 0622

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