

The Occupational Profile as a Guide to Clinical Reasoning in Early Intervention: A Detective's Tale

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ABSTRACT

According to the *Occupational Therapy Practice Framework: Domain and Process, 3rd Edition (Framework)*; American Occupational Therapy Association [AOTA], 2014), all initial client evaluations must include an occupational profile and a subsequent analysis of occupational performance. It is through the process of completing the profile that the therapist begins to learn about the client's background, priorities, and desired therapeutic outcomes. Completion of the profile also begins dialogue regarding the possible effect of factors, patterns, skills, and context and environment on the client's ability to fully participate in activities of daily life.

One can think of the occupational profile as a systematic way to organize the therapist's clinical reasoning. When presented with a client with complex needs, having a methodology to guide evaluation and develop an informed intervention is critical for effective outcomes. Take the case of a child with complex medical concerns who lives in an underserved, rural environment: Having a tool to guide one's reasoning process becomes essential for identifying and resolving the unique barriers limiting occupational engagement.

LEARNING OBJECTIVES

After reading this article, you should be able to:

1. Recognize how using the AOTA Occupational Profile Template guides clinical reasoning
2. Identify key decision points using clinical reasoning to assess and develop a plan of care for a child with a complex medical disorder

3. Describe the distinct value of occupational therapy in early intervention using terminology from the *Framework*
4. Recognize the process of using inductive and deductive reasoning as part of the clinical reasoning process during early intervention cases

INTRODUCTION TO THE OCCUPATIONAL PROFILE

The occupational profile helps create a summary portrait of a client viewed as an occupational being, organizes the evaluation around the activities the client wants to do but has difficulty with or cannot do, and frames the process of inductive reasoning. The occupational profile is an essential tool to improve the quality of occupational therapy services and demonstrate the profession's distinct value to other health care providers, reviewers, and payers.

The American Occupational Therapy Association (AOTA; 2017) has developed an Occupational Profile Template to assist occupational therapy practitioners with this process regardless of their practice setting. Interventions developed by occupational therapists (OTs) must always be based in theory and focused on meeting the unique occupational needs of the client and, if applicable, their family, rather than on a condition. Completed occupational profiles can be incorporated into an electronic medical record.

The purpose of this continuing education article is to demonstrate how the occupational profile can be used in early intervention. The case example is based on a real client and the profile developed for that family. As such, some of the specifics may not generalize to all children. Still, the process of using the Occupational Profile Template to articulate and describe the distinct value of occupational therapy during early intervention is offered as a contribution to the larger scholarly discussion within the profession.

The evaluation data is obtained from the client's perspective or, in the case of a child, through observation and interview with the family and caregivers. These formal and informal conver-

sations are examples of strategic interviews that lead to an individualized, routines-based, client-centered approach to intervention. The Occupational Profile Template provides an outline of occupational concerns that should be addressed when completing the occupational profile for an individual (AOTA, n.d., 2017).

Occupational therapy practitioners are mystery solvers and problem solvers. When conceptualizing the approach to intervention, therapists must start with an evaluation of the client to better understand what they can and cannot do, and what intervention would enable functional participation. You might say occupational therapy practitioners are “lifestyle detectives,” who search for clues, test hypotheses, interpret findings, determine conclusions, and disseminate discoveries. Occupational therapy practitioners solve mysteries by profiling or creating portraits of clients, examining clues within contexts, and synthesizing all the collected data points that are then summarized and provided to the client in the form of a plan (Whitney & Luebben, 2014). The art and science of the evaluation process guides the therapist to develop functional goals that meet the needs and values of the client (Reynolds et al., 2017), but as with all great sleuths, a formula for inductive and deductive thinking is essential.

A great deal of what occupational therapy practitioners learn is associated with specific conditions, but people often have complex patterns of dysfunction. The mystery facing occupational therapy practitioners is: What is the problem that needs to be overcome, and what are the barriers this person is experiencing that block them from what they want to accomplish? Once the OT identifies the problem of the case, they must isolate what they know and what they need to know; suggest a strategy and a theoretical approach; and after implementing the strategy, again evaluate to determine whether the client perceives their problem has been solved.

Fans of mysteries may recognize this process as a profile used by detectives, and many of the most popular TV dramas today take viewers through the journey of expert FBI profilers who gather data from a crime scene and use that data to profile the unknown subject, who will, oftentimes, be found through the use of this articulated profile. FBI profilers use environmental and contextual clues for recording and analyzing the psychological and behavioral characteristics of a person to build a picture—a portrayal of the unknown subject involved in the crime. The profiler uses this picture to narrow down the potential perpetrator and to solve “who done it.” OTs are mystery solvers who also use a systematic evaluation, the occupational profile, to record and analyze a client’s mental and physical characteristics, assess and predict capabilities, and deduce the best intervention to optimize functional outcomes.

As with a detective, gathering client information follows a systematic approach to critically evaluate and clinically portray the function and dysfunction of the individual. OTs use both inductive and deductive reasoning to understand and resolve barriers of occupational engagement. When combined, these two forms of reasoning result in clinical reasoning within the profession.

For example, inductive reasoning would be used when considering how a specific child behavior can help move the family to understand and form more generalized conclusions about the behavior, whereas deductive reasoning might be used to take a larger theoretical construct—say the use of Ayres’ Sensory Integration (ASI) theory to support a specific conclusion (Schaaf et al., 2018; Whitney, 2018).

Each detective has their tools. One of my favorite mystery writers uses cooking to help her organize, categorize, and synthesize her reasoning when solving murders (so many murders!) in her small town (Davidson, 1992). OTs have our own tools to shape our reasoning on the best ways to help each client.

THE FIVE STEPS OF CLINICAL REASONING

Clinical reasoning follows a five-step process of decision making:

1. Appraise the evidence, including the data provided in a referral and through strategic interviews.
2. Develop a clinical hypothesis to organize and guide assessment.
3. Use the data collected.
4. Problem solve to evaluate the clinical hypothesis.
5. Test the clinical hypothesis (Cronin, 2018).

The Occupational Profile Template organizes clinical reasoning, beginning with the purpose of the referral and prompting the therapist to consider areas of occupational competence (function) and challenge (dysfunction) as part of the client report. Ideally, as the therapist works to gather data about function and dysfunction and notes the influence of the environment and context, a clinical hypothesis begins to emerge from the well-organized data collected. The profile leads the therapist to create client-centered goals specifically directed toward resolving areas of occupational dysfunction documented in the profile. The final step of intervention is to return to the client’s goals to assess whether they have been met.

The template organizes and serves to frame the client as an occupational being, one with occupational potential and capacities. A client report is developed to document the client’s reasons for seeking services, occupational strengths, values, history, and performance patterns (routines, roles, habits, and rituals). These constructs are operationalized in the *Occupational Therapy Practice Framework: Domain and Process* (3rd ed.; AOTA, 2014). Occupational engagement is profiled by evaluating the client’s environment and context, specifically what supports or impedes occupational engagement in the physical, social, cultural, personal, temporal, and virtual contexts. Data from the profile guide the generation of client goals and priorities, as well as outcomes targeted for intervention, intervention type, and approach.

Bandura (1986) postulated that people learn by observing, imitating, and modeling others. The social context, the expectations and relationships with others in the environment, and the cultural context, including expectations of society and routines within the family, create the cultural context that, in turn, influences client identity and activity patterns. Together, these create a profile or portrait of a client as an occupational being.

In the case of pediatric practice, children live within the context of their families and participate in the routines of that family within the sociocultural environment (Primeau, 1998; Schaaf et al., 2011). In the area of West Virginia where this article's case example takes place, the social ecology is characterized by family networks, traditional gender roles, and a complex fatalism (a belief that all events are predetermined and inevitable, and personal power is impotent in terms of changing one's fate; Rural and Appalachian Youth and Families Consortium, 1996). The Appalachia Regional Commission defines Appalachia as being made up of sections of 12 states spanning New York to Mississippi. West Virginia is the only state in which all of its counties are part of Appalachia. In the case example presented in this article, contextual clues are essential to closing the case of occupational dysfunction (West Virginia Early Childhood Transition Steering Committee, 2008).

CASE EXAMPLE: ROSE

Rose was a 3-year-old girl with complex medical needs who lived in rural Appalachia. The occupational profile was completed for Rose as part of a larger, multidisciplinary team assessment provided as part of a summer camp program specifically for children with complex medical disorders. The cost for participants is covered through a grant from the U.S. Department of Education. Families initially meet with multidisciplinary team members, who conduct an evaluation and plan treatment. Throughout the week the families move between various labs, each of which provides specialized services.

The Occupational Therapy Template provided an understanding of Rose's perspective and background and helped identify priorities and desired targeted outcomes that the family believed would lead to Rose's engagement in occupations and support her participation in family routines (AOTA, 2017).

Client Report

Articulate the reason the client is seeking service: What are the concerns related to engagement in occupations? Why is the client seeking service, and what are the client's current concerns relative to engaging in occupations and in daily life activities? (This may include the client's general health status.)

- Rose presented with autism, cortical visual impairment, and hypotonia. Rose was referred for an occupational therapy evaluation as part of a comprehensive, interdisciplinary team evaluation to determine appropriate interventions.
- Rose's parents were not sure she could hear, and they expressed additional concerns about her vision. Sometimes she seemed to hear, sometimes she seemed to see, and other times she was unresponsive to auditory or visual input. The family was seeking services to improve functional mobility and communication and to learn strategies to reduce Rose's frequent meltdowns during family routines.

Effect on Occupation

Rose's mother described her as "fully dependent" on the family, with the mother as the primary care provider of Rose and her 6-year-old brother. The father worked at a grocery store and, as the family only had one car, the mother had limited access to community resources for assistance in caregiving. The mother was an artist and musician who hoped to return to work once the children were in school.

What are the occupations in which the client is successful (i.e., function) or areas that are not at the expected level of function (i.e., dysfunction)? In what occupations does the client feel successful, and what barriers affect their success?

Rose was described by her parents as a "very picky eater." She was still nursing and used nursing as a primary coping strategy when she felt overwhelmed or stressed. Her mother stated this limited her own ability to pursue her interests away from Rose.

Communication with Rose was primarily through simple gestures, with some basic signs used for words such as *father*, *more*, *all done*, *music*, *fish* (for Goldfish crackers), and *sing*. For instance, Rose placed two hands on her head to request a favorite song. Many of these communication strategies were idiosyncratic and understood only by the family.

Volitional movement was limited: the family carried Rose everywhere, using a front-pouch baby carrier. Her mother and father took turns carrying her.

Rose could crawl short distances and walk about five steps with help (the mother or father would hold her hand). After five steps or so, Rose would typically sit on the floor and then crawl to her mom to nurse. Attempts to place her in mobility devices such as strollers or grocery carts were unsuccessful—Rose would thrash to get out, cry, and otherwise appear very distressed.

All self-care tasks were dependent, and the sleep schedule was erratic given Rose was still in diapers and not yet able to control her bowels or bladder.

The family had several routines that engaged Rose in play and social interaction, including singing, simple signing, and playing with a toy drum. Rose enjoyed it when her dad swung her between his legs and up above his head. Overall, Rose had a limited range of play schemes. She was able to retrieve 10/10 mini M&Ms from a busy patterned blanket. However, she retrieved 0/10 non-candy items from a solid background.

Rose's performance with novel tasks improved when they were presented in quiet environments. She was intolerant of the sound and vibration from rolling wheels. She was provided pink high-top tennis shoes that lit up, and a walker. With these modifications, she was willing to stand and demonstrated bilateral reciprocal movement in the lower extremity (walking about 10 steps). Combining noise-cancelling headphones with a stroller improved her tolerance.

Rose's vision and hearing were tested as within normal limits, with behaviors (avoidance) affecting functional use.

What are the client's values and interests (i.e., personal interests and values)?

Rose had a small musical toy drum that played a song she enjoyed, and she would dance (seated) when the music was played. When challenged to perform a novel task, Rose crawled into her mother's lap to nurse. Rose appeared to be easily engaged by music.

What is the client's occupational history (i.e., life experiences)?

The mother stayed at home to care for the two children (Rose and her 6-year-old brother) and stated she missed her own work as a musician. She reported feeling "trapped" at times as well as feeling guilty for these feelings.

The mother was limited in her ability to participate in her son's community and school activities due to her responsibilities with Rose and lack of independent transportation.

The dad was the sole financial supporter of the family, working at the local grocery store as a checker, a position that did not provide health care benefits.

Rose's parents were very concerned about Rose's ability to learn (e.g., could she see or hear, what were her developmental delays, why was she so avoidant of noise from the stroller or grocery cart?).

What are the daily routines in the family and habits within those routines (i.e., performance patterns—routines, roles, habits, and rituals)?

- Rose could imitate simple, familiar gestures. She was overly avoidant of novelty and got overwhelmed quickly.
- Her parents reported that Rose loved M&Ms. Her mother carried a container of mini M&Ms to motivate Rose to behave in certain ways.
- Rose could manipulate familiar items, such as a small favorite toy drum that played music. Her performance improved when she was in a quiet area with minimal distractions.
- Rose was able to demonstrate understanding the expectation to point to picture cards and select icons for preferred activities (e.g., swing, M&M, Goldfish).
- Rose was unable to isolate her index finger for pointing. Her mother was shown how to provide facilitated guidance (supporting Rose's arm to reduce gravity), which compensated for limited shoulder strength/mobility and improved Rose's ability to isolate her right index finger and point to provided visual prompts (90% accuracy). Rose signed "more" to continue with this task for several trials, clapped, and seemed pleased with her success.
- In the motor lab, the therapists tested an adapted bike. With her feet strapped to the pedals, Rose's parents pushed Rose down the hall while she held onto the handles and her feet moved with the pedals. Rose appeared to enjoy the movement provided as her legs moved with the bike, guided by her parents.
- Next, Rose was fitted with pink high-top tennis shoes that lit up and made a squeak sound when she stepped. Her weight

was supported by her parents, who held her by the hands as she walked. Rose seemed very pleased with these shoes, stepping to create the sound and light. Once seated, Rose raised her leg to show first her mother then her father her shoes. When asked to try the communication devices, Rose cried and crawled to her mother to nurse. Testing was discontinued and resumed the following day. The testing room and situation were modified—the lights were dimmed, the music of the communication devices was turned off, and Rose was provided the opportunity to swing in a spandex hammock before participating in the testing. Reducing sensory input and making environmental modifications resulted in clear, consistent, and observable increase of purposeful performance: Rose was able to follow cues to touch the device with 80% accuracy and to persist with the task for 8 minutes before asking to swing. Her performance improved when in a quiet area with minimal distractions.

What aspects of the client's environments or contexts do they see as supports and barriers to occupational engagement?*Physical (e.g., buildings, furniture, pets)*

- Rose was fearful of being moved in a stroller or other device with wheels (she appeared to be fearful of the noise or vibration). She was extremely avoidant (her parents used the word "terrorized") of the sound and movement of a grocery cart if they attempted to put her in one to complete their shopping.
- Avoiding movement limited the family's ability to participate in many activities outside the home.

Social (e.g., spouse, friends, caregivers)

- Rose had a supportive family who had been receiving services through the Birth to Three program. Her mother felt isolated at home as Rose's primary care provider for most of the day and with limited interaction with friends and family.
- Rose used immature strategies to get her needs met, such as crying and using avoidant behaviors when challenged by a task. There were few children in the area and none within walking distance.

Cultural (e.g., customs, beliefs)

- The family and community network was strong—the extended family provided financial and respite support.
- The rural, low socioeconomic setting had limited access to resources (no public transportation, educational resources were limited). The mother was hesitant to express her own needs as she didn't want to complain or sound like she wasn't grateful for Rose.

Personal (e.g., age, gender, supplemental educational services, education)

- Rose was a 3-year-old child in rural Appalachia. She had an older brother (age 6) and lived with her mother, father, and brother in a small (1,000-square-foot) home.

- The family income was less than \$20,000 per year, with health care provided through Birth to Three and Medicaid.

Temporal (e.g., stage of life, time, year)

- Rose was in the pre-operational period of cognitive development. She did not attend pre-school or day care—there were no programs in the area that her parents believed could meet Rose's needs at that time.

Virtual (e.g., chat, email, remote monitoring)

- The family had one cell phone that they shared. They had limited access to the Internet (they could use the computers at the library). There were three radio channels in their community, and they did not have access to cable channels on television.
- No broadband was available in the rural community, limiting access to communication and services.

Client Goals: Client's Priorities and Desired Targeted Outcomes

Rose's parents wanted her to be able to communicate with others outside the family as well as improve her ability to express her needs to them. They were concerned about functional mobility and hoped to find a way to make a stroller or similar device acceptable to their daughter. They expressed a desire to find strategies that would help Rose develop a greater range of frustration tolerance.

Approaches included:

Reduce impairment: Improve functional mobility by addressing sensory motor development. Reduce sensory-adverse barriers to participation and exploration.

Compensatory strategies: Provide opportunity for exploratory play on stomach and other planes to facilitate performance.

Assistive technology: Provide assistive technology to promote communication and mobility.

Adapt environment/occupation: Construct environments that entice play and engagement using sensory exploration, following Rose's lead.

Provide assistance/caregiver training: Provide training for parents in safe movement/input for Rose. Promote understanding of expected developmental milestones and setting up sensory-friendly learning experience using routines-based activities (i.e., stirring batter while making weekly pancakes).

Profiling Rose: Solving the Case

Theory helps move the steps of clinical reasoning from theory to intervention. ASI theory was identified as the primary theoretical approach to guide intervention with Rose. ASI is a developmental theory that assumes children acquire sensory-based motor function in predictable order (Ayres, 1979). In Ayres' theory, SI is an individual's ability to respond adaptively to sensation over a broad range of intensity and duration. When sensory input is "integrated," the individual can use sensory information to support optimal arousal, attention, and activity levels to meet the demands of the environment in a fluid, flexible manner or respond in an

adaptive way. When sensation is perceived and processed in a disordered way, responses to that sensation are disordered as well (Whitney, 2018).

The function–dysfunction continuum within this theory characterizes *function* as the ability to regulate daily responses to sensory events and *dysfunction* as nonadaptive responses to sensory situations. OTs assess the function within each sensory system as well as the person's ability to integrate multiple sensory information for functional use (Kramer & Hinojosa, 2010; Schaaf & Mailloux, 2015).

The postulate regarding change guides intervention to support the child in achieving an optimal level of arousal by facilitating the child's development of self-regulation; improving sensory processing; and providing opportunities to integrate sensory, motor, affective, communicative, and higher-level skills through developmentally appropriate play-based learning opportunities. Behavioral modification is identified as a secondary approach. This theory postulates that behavior is a response that is strengthened when a reinforcement is provided. Reinforcements can be positive or negative (Skinner, 1976). The postulates for change addressed by these two theories are then used to frame the intervention—that is, to organize the theoretical material and translate that information into practice.

The occupational profile provides a document that allows the next therapist or reader to deconstruct the clinical reasoning of the original interventionist. The five steps of clinical reasoning can be identified through the occupational profile created for Rose. Step one of clinical reasoning is to assess the evidence. For the OT, part of the detective work was aimed at differentiating Rose's patterns of performance—were her habits because of underlying dysfunction, learned behavior, or immature sensory processing and integration? The occupational profile helped guide the clinical reasoning to generate a clinical hypothesis.

For example, Rose's parents provided information about their child that the therapist combined with information in the reports from the early intervention team. Additional data was gathered through observation and testing (step 1). The function–dysfunction continuum was created—what one might expect from a child of this age given the resources available in the environment and the contextual influences. The evidence was organized in the client report section of the profile and a hypothesis was generated (step 2). The OT began to form a hypothesis—a profile of the client in this case.

When observing Rose's response to visual stimuli, and using the assumptions outlined in behavioral theory (rewarding participation with M&Ms or songs; step 3), the OT hypothesized that Rose's willingness to respond to tasks when rewarded did not support engagement in the presented activities (step 4). The detective needed a different hypothesis (step 5).

Understanding Rose's poor frustration tolerance as a response to feeling overwhelmed by sensations in the environ-

ment provided the family with a new way of supporting Rose's engagement in daily routines.

The profile culminates in articulating client-centered goals to resolve areas of occupational dysfunction and will allow for assessing when the client's goals have been met. For an FBI profiler, this would be the moment when the characteristics of the suspect are released to the public, generating leads that lead to offender's capture—case closed. For the OT, this is the point for intervention to be offered, response to intervention observed, and data from that observation used to plan future intervention strategies.

In the case of Rose, intervention strategies following ASI theory guided the OT to provide sensory intervention to prepare Rose to be able to meet sensory challenges and to improve her occupational engagement. By the end of the week, Rose was able to demonstrate understanding the expectation to point to picture cards and select icons for preferred activities (e.g., getting to swing, receiving M&Ms or Goldfish), when provided with a quiet, less distracting environment. After the OT reduced the sensory input from the communication device provided to Rose by the speech pathologist, Rose completed the camp able to use the device without having a tantrum. Follow up from the early interventionist will continue to build on this foundation.

The final steps of clinical reasoning direct the therapist to return to the clinical hypothesis to assess whether the hypothesis was correct. This is accomplished in part by assessing the outcome of intervention. In this case, we return to Rose and her family.

Rose was very pleased with her shoes, stepping to create the sound and light. When seated, she raised her leg to show her mother or father her shoes. Rose benefited from swinging and other sensory strategies that provided movement within safe play routines. As her comfort with movement increased, and with the incentive of the sound and light, Rose become more tolerant of the mobility devices provided and with fine motor activities. Her family demonstrated this new ability to incorporate frequent rest breaks and activities to promote sensory modulation and to compensate for Rose's poor endurance (sensory motor dysfunction). Finger isolation and hand function improved when Rose was provided with assistance to compensate for limited shoulder strength and mobility.

Her parents were relieved that Rose was able to hear and respond to direction when she was afforded a supportive environment, and they expressed their excitement to build on this new skill. They were optimistic that Rose might be able to attend pre-school and benefit from participating in the local day care environment.

CLINICAL IMPLICATIONS

The occupational profile enabled the OT to prioritize care in collaboration with the family and detect barriers to occupational engagement. The clinical reasoning steps guided the systematic profiling of this case. Outlining the approach to intervention

frames the process the therapist will use to gather observational data during intervention. Using the occupational profile supported the OT to highlight the distinct value on the team. Having the parents describe their experience of raising a child with development delay, and understanding their perception of how intervention would promote adaptation to their family routines, helped inform the quality of care within the larger, multidisciplinary team.

Once a detective solves a mystery, they have to share their findings in a way that allows others to follow the line of reasoning that connects the disparate clues and resolves the mystery. Documenting occupational therapy services is equally important. Long after the services are provided, documentation remains as evidence of the occupational therapy services a client received. Occupational therapy practitioners share their distinct contribution to clients through their documentation. The Occupational Profile Template can be inserted directly into the treatment record which allows another therapist to follow along with the documented clinical reasoning skills outlined in the profile and learn from the documented therapeutic process of the practitioners who wrote the documents. Documentation can be well written or poorly developed and uninformative. Practitioners are wise to note: Both writing styles have equal longevity.

CONCLUSION

The occupational routines of a family raising a child with complex medical disorders in rural Appalachia benefited from the clinical reasoning approach afforded and framed by the Occupational Therapy Profile Template. Intervention is first guided by the theoretical approach, with assumptions stipulated that align with and follow the evidence provided through the theory. Data are gathered and analyzed using the assumptions and expectations proposed or postulated by the theory.

Once the function–dysfunction continuum is created for the client report, a clinical hypothesis can be developed, client goals generated, and the intervention planned. These aspects of the client are organized and articulated following the template of the occupational therapy profile. The profile is of critical importance for early intervention practitioners, who are naturally attuned to the types of and extent to which occupations, habits, routines, and rituals are involved in a typically developing child's daily life.

The document allows for a comprehensive record that demonstrates clinical reasoning and problem solving individualized to optimize development for the client. Understanding the profile of family routines can strengthen the translation of evidence to practice. 📄

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Learning Level: Intermediate

Target Audience: Occupational Therapists and Occupational Therapy Assistants

Content Focus: Process of Occupational Therapy: Evaluation

1. **There are five steps in clinical reasoning. Which of the following is the final step?**
 - A. Evaluate whether the client perceives their problem has been solved.
 - B. Appraise the evidence.
 - C. Develop a clinical hypothesis to organize and guide assessment.
 - D. Test the clinical hypothesis.
2. **After seeing a child rock and hold her ears during circle time, generalizing that the child may find loud noises overly stimulating based on Ayres' Sensory Integration® theory is an example of:**
 - A. Deductive reasoning
 - B. Inductive reasoning
 - C. Problem solving
 - D. Executive function

3. **A child withdraws to his mother's lap and insists on nursing after being asked to play with a toy that lights up and plays music. Concluding that the child finds noise or light to be overly stimulation or frightening is an example of:**
 - A. Deductive reasoning
 - B. Inductive reasoning
 - C. Problem solving
 - D. Executive function

4. **Data from which one of the following tools guide the generation of client goals and priorities as well as outcomes targeted for intervention, intervention type, and approach?**
 - A. Sensory profile
 - B. Occupational profile
 - C. Therapeutic hypothesis
 - D. Master module

5. **Which one of the following was *not* mentioned in the article as a contributor to the profile of a child as an occupational being?**
 - A. The social context
 - B. The expectations of and relationships with others in the environment
 - C. The cultural context
 - D. Temperament

6. **The primary purpose of an occupational profile is to:**
 - A. Organize the evaluation around the activities the client wants to do but has difficulty with or cannot do
 - B. Document progress for payer
 - C. Ensure reimbursement
 - D. Promote the distinct role of occupational therapy in practice

7. **Which of the following is *not* included in the client report section of the Occupational Profile Template?**
 - A. Cultural context
 - B. Occupations in which the client is successful
 - C. Personal interests
 - D. Performance patterns

8. **Which of the following circumstances would belong in the context portion of the Occupational Profile Template?**
 - A. The home has five steps leading to the front door.
 - B. The child is 3 years old.
 - C. The child cries and uses avoidant behaviors when presented with a challenge.
 - D. Social supports and barriers to occupational engagement

9. **In a 3-month follow-up with Rose, which one of the following outcomes would you expect her parents to report to you given the profile presented for her?**
 - A. Rose was able to respond to verbal prompts without avoidant behaviors in five out of seven trials.
 - B. Rose could indicate she wanted more glue for her art project from her Sunday school teacher.
 - C. Rose was able to ambulate 20 feet without fatigue.
 - D. Rose was now able to dress independently.

10. **In what way was the virtual context identified in the occupational profile presented?**
 - A. No broadband was available in the rural community, limiting access to information and communication.
 - B. The family could not use the Internet for social activity.
 - C. Rose could use the computer for her homework.
 - D. The family did not have television.

11. **The primary purpose of documentation as identified in the article is to:**
 - A. Provide evidence of occupational therapy services received by the client
 - B. Advocate for the profession
 - C. Determine frequency and duration of continued services
 - D. Connect disparate clues for problem solving

12. **Which of the following is *not* true of the Occupational Profile Template?**
 - A. It can be inserted directly into the treatment record.
 - B. It allows another therapist to follow along with the documented clinical reasoning skills outlined in the profile.
 - C. It helps the next therapist reading the profile learn from the documented therapeutic process of the previous therapist.
 - D. It provides a release in the health record for future researchers.

Now that you have selected your answers, you are only one step away from earning your CE credit.



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