

zawodników-sportowców. Ból jest konstruktywny jedynie wtedy, gdy ogranicza się go do okresów intensywnego treningu, po których nie następują skutki uboczne.

Ból w nawiązaniu do ryzyka. W świecie sportowców uznaniem cieszy się ten zawodnik, czy zawodniczka, którzy potrafią grać, biegać, mimo odczuwanego bólu, który powstał w wyniku kontuzji. O takich zawodników mówi się, że mają charakter. Niestety, igranie z bólem i kontuzją może spowodować nieodwracalne szkody w organizmie. Wydawać by się mogło, że w związku z pojawieniem się zawodowych lekarzy sportowych ilość zawodników podejmujących ryzyko zmalała. Jednakże nie zmniejszyła się liczba sportowców podejmujących wyzwania wynikające z pozytywnego wizerunku podejmowania trudu związanego z przekraczaniem bariery bólu. Dlatego wydaje się rzeczą niezwykle ważną zrozumieć, dlaczego sportowcy ryzykują udział w zawodach pomimo kontuzji i bólu.

W tym wszystkim ważne jest, aby pamiętać, że kiedy sportowiec cierpi z powodu kontuzji jego reakcja na ból będzie zależeć również od konkretnego środowiska sportowego, do którego należy.

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Dirk Caulier
University of VIVES
Bruges, Belgium

CLIENT CENTERED WORKING & THE USE OF THE COPM INTO OCCUPATIONAL THERAPY

The "doctor-prescription model" is increasingly disappearing from the image of the medical world and clients are encouraged to become more participant. This also applies to occupational therapy. Whereas previously the therapist almost exclusively determined the content of the treatments, the therapist increasingly takes on a guiding and coaching role within the rehabilitation process, which is largely determined by the rehabilitation person himself. This article explains the origin, application and benefits of a client-focused approach.

Key words: client centred, occupation, Canadian Occupational Measure, Canadian Process Practice Framework, Canadian Model of Occupational Performance and engagement, occupational therapy.

Клієнто-орієнтована робота і використання копм (сomp) в ерготерапії. "Модель лікаря, що випишує рецепти" зникає з медичного світу, а натомість розвивається практика активнішого залучення до роботи пацієнта. Це також стосується ерготерапії. Якщо раніше терапевт майже виключно визначав зміст лікування, то сучасний терапевт все частіше бере на себе керівну та тренерську роль в процесі реабілітації, що значною мірою визначається самою реабілітаційною особою. Ця стаття присвячена походженню, застосуванню та визначенню переваги підходу, орієнтованого на клієнта.

Ключові слова: орієнтованість на клієнта, заняття, канадська ерготерапевтична система оцінювання, канадська практика, канадська модель професійної діяльності та залучення, ерготерапія.

Client centred working is an approach based on the uniqueness of people and respect for differences in socio-cultural background, norms, values and choices. The client has an active role and responsibility in formulating and solving his own experienced problems. The occupational therapist listens to the client's story. The occupational therapist provides information so that the client can make choices to find new ways of dealing with problems with the help of his own strengths and strategies. In a client centred treatment, the interaction between the person, his environment and acting is central. Good and open communication between client and therapist is essential (Cardol & Dedding, 2000).

Client centred working was devised by the humanist Rogers. According to him, clients should have a greater influence on the content of their treatment. In essence, a therapist enters into a partnership with the rehabilitation person. The rehabilitation person is the experience expert; the therapist recognizes and uses the experience and knowledge of the rehabilitation person. The rehabilitation person is actively involved in the treatment and decides for himself what to work on. This is formulated by Cup & Thijssen (2004) as follows: the essence of client-oriented work is that the client and the therapist both have expertise and jointly negotiate treatment goals and treatment strategies with respect for each other's expertise.

It has been proven that people with disabilities from the upper (and lower) extremity can make important, positive progress by receiving client centred occupational therapy. In addition, an article by Cardol & Dedding (2000) describes that client centred work

and the identification of problems in acting from the client's perspective saves time, because the treatment plan is more focused on areas that are relevant to the client.

An improvement or change in behaviour can only be significant if it is in accordance with the unique situation of the rehabilitation person and his vision on occupation. It is up to the therapist to investigate which activities are important for the rehabilitation person and why these activities are important. The story of the client is important to uncover that meaning. The story of the rehabilitation person also gives information about habits and values, what the demands of the rehabilitation person are or the value of performing daily tasks (Cup & Steultjens, 2005).

A client-oriented instrument is needed to clearly identify these activities and changes.

The importance of a client centred approach leads to more motivated clients, better functional outcomes, shorter admissions and dismissal to more independent forms of living compared to a standardized, protocol-based approach that is not based on the individual, meaningful roles and activities of the client in his environment (Cup & Steultjens, 2005).

The Canadian Occupational Measure is based on the Canadian Model of Occupational Performance and has as extra dimension "spirituality" - the essence of the human beings.

The motives, interests and norms indicate the perception of action. Acting is central; this means working at activity and participation level.

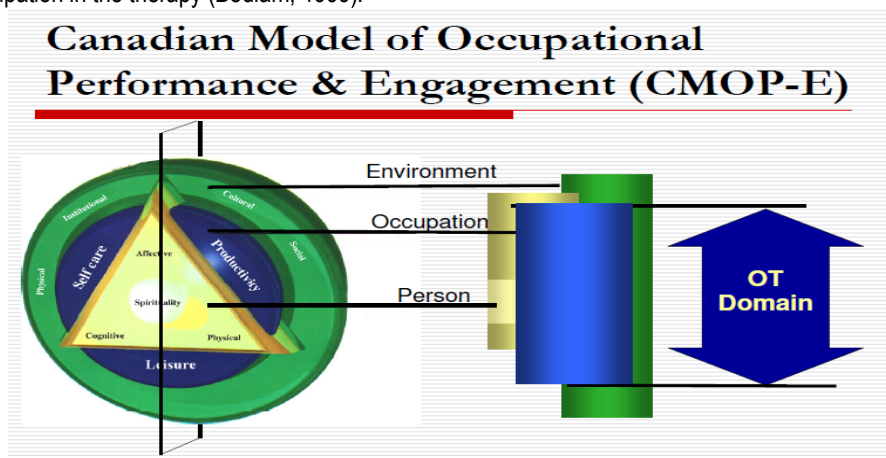
Elements to substantiate the model are:

- the unique value of an individual;
- the holistic view of people;
- a human action model;
- the therapeutic use of activities;
- the human developmental stages.

The Canadian Occupational Measure is a reliable and valid instrument, designed to be used with all diagnostic groups and with clients of all ages. It is used to map the goals of the rehabilitation person and to measure changes over time through the client's self-evaluation of his actions. The measure can be administered at various times in the treatment process. It can be used as an intake or shortly after it, but it can also only be used if the treatment process is getting stuck. It is important that a rehabilitation person is able to act and experience the problems he encounters by doing his daily activities (Cup & Thijssen, 2004).

The instrument is administered by a semi-structured interview. The occupational therapist can use his own style and conversation techniques appropriate to a client centred approach. When the client is satisfied, the effect of the therapy is greatest.

An article from Bodiam (1999) describes a quote (Pollock, 1993) that, if the client is not the one who reports the problems, the client will not be the one who solves the problems. When the rehabilitation person sets his own therapy goals, there is an active and motivated participation in the therapy (Bodiam, 1999).



Polatajko, H.J., Townsend, E.A., Craik J. (2007). Canadian Model of Occupational Performance and Engagement (CMOP-E). In E.A. Townsend and H.J. Polatajko, Enabling Occupation II: Advancing an Occupational Therapy Vision of Health, Well-being & Justice through Occupation p.23 Ottawa, ON: CAOT Publications ACE.

According to Bodiam (1999), COPM supports the statement that rehabilitators can be responsible for their own recovery options and the rehabilitation process.

In an article by Cup & Thijssen (2004) it is concluded that the COPM generally makes a useful and valuable contribution to occupational therapy diagnostics for clients after a stroke. The article also shows that there are several factors that influence the effective use of COPM:

- level of the rehabilitation person (illness insight, communication disorders);
- level of the therapist (experience, routines);
- level of the institution (policy, expectations).

The ideal client for purchasing the COPM has a view into his problems, is able to articulate these problems and is also in possession of a good problem-solving capacity. The therapist uses his professional knowledge and experience to inform the client, so the client can make choices to find new ways to deal the problems using his strengths and other strategies.

Sometimes it's difficult for clients to formulate problems in occupation (due to lack of view, lack of experience of problems,

communication problems); applying a client-oriented approach can be difficult, but not impossible.

Knowledge of the Canadian Practice Process Framework can help therapists to realise a client entered approach in practice.

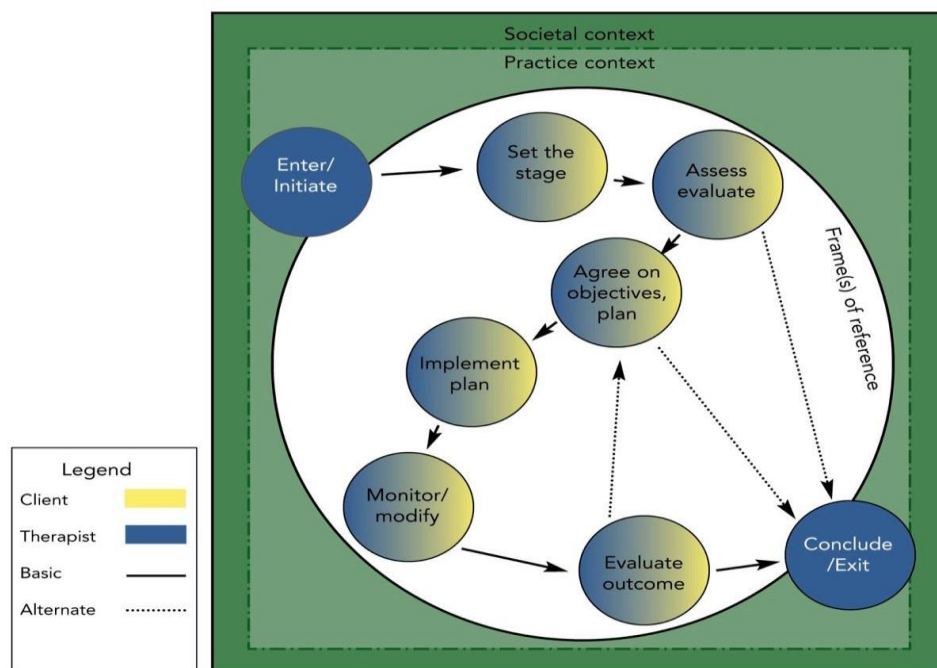
The Canadian Practice Process Framework (CPPF) is comprised of four elements: three contextual elements, and an element depicting the practice process.

The three contextual elements include: the societal context, practice context, and frames of reference.

- Societal context – the client and therapist are both situated in a broader societal context comprised of elements from the a) cultural, b) institutional, c) physical and d) social environments. (Townsend & Polatajko, 2007, p. 235)
- Practice Context – embedded within the broader societal context, the process begins with the initiation of the referral and is influenced by the corresponding personal and environmental factors that the client and therapist bring to their interactions.
- Frames of Reference – defined as sets of interrelated theory, constructs, and concepts that determine how specific occupational challenges are perceived understood and approach that help guide clinical decision making (Townsend & Polatajko, 2007, p.243) Frames of reference include models of practice, theories, and methods of service delivery.

The fourth element depicts the occupational therapy process and is described in eight action points which can be used in their entirety, or in selected pathways through the process. There is flexibility in the process, considering the contextual elements. The CPPF's eight action points:

Figure 9.1 Canadian Practice Process Framework (CPPF)



Polatajko, H. J., Craik, J., Davis, J., & Townsend, E. A. (2007). Canadian Practice Process Framework. In E. A. Townsend and H. J. Polatajko, *Enabling occupation II: Advancing an occupational therapy vision for health, well-being, & justice through occupation*. p. 233 Ottawa, ON: CAOT Publications ACE.

- Action Point 1: Enter / Initiate

Who is the client? An individual, family, group, organization or community?

Does it appear that the client needs occupational therapy?

What is the client's perceived occupational challenges?

Has the client consented to participate in occupational therapy?

What model of service delivery seems most appropriate to work with the client?

- Action point 2: Set the stage

Can you provide what the client needs?

What are the client's perceived or potential occupational issues?

What are potential occupational goals for the client?

What theoretical framework will guide the assessment process?

- Action point 3: Asses/evaluate

What needs to be assessed based on the frame(s) of reference selected in "Set the stage"?

How should the assessment be conducted?

What do the assessment findings mean in terms of the client's occupational issues?

Should your interaction with the client continue to the next action point or end at this point? The interaction may end if no goals or occupational issues are noted; the referral was for assessment and recommendations only.

- Action point 4: Agree on objectives and plan

What are the occupational goals that the client wants to work towards?

What action-based objectives need to be achieved to reach the goals?

How will the objectives be achieved?

Does the plan consider the occupational goals, objectives, background, assessments findings, a timeline, requirements, stakeholder involvement and evaluation methods?

Should your interaction with the client continue to the next action point or end at this point? Note that the relationship may end at this point if you are in a consultation role, you and the client may agree that you are no longer needed, or the referral may specify that the consultation ends with a plan established.

- Action point 5: Implement the plan

What needs to be done to implement the plan?

Who needs to act?

What enablement skills should you use?

What frame of reference is guiding the implementation of the plan?

How is the client engaged through occupation to implement the plan?

- Action point 6: Monitor and modify

Is the plan being implemented as anticipated?

Is progress being made towards achievement of the objectives and occupational goals?

Have there been changes to any of the contextual factors affecting implementation?

Are there modifications needed to ensure successful achievement?

- Action point 7: Evaluate outcome

Have the client's previous occupational goals, issues or challenges been addressed through implementation of the plan?

Are there further occupational issues that should be addressed?

Should the practice relationship continue by returning to point 4 "Action" or conclude at this point?

- Action point 8: Conclude/exit

Do you and the client agree that the practice relationship should conclude?

What documentation is required for a final report?

Are further referrals needed for other services?

Is the client clear on how to re-enter an occupational therapy practice relationship if needed?

The next chapter explains the use of the Canadian Occupational Performance Measure.

The Canadian Occupational performance Measure is an evidence-based measure designed to capture a client's self-perception of performance in everyday living over time. Originally published in 1991, it is used in over 40 countries and has been translated in 35 languages.

The test is taken in five steps:

- Problem definition

The COPM is a personalized, client-centered instrument designed to identify the occupational performance problems experienced by the client. Using a semi-structured interview, the therapist initiates the COPM process by engaging the client in identifying daily occupations of importance that they want to do, need to do, or are expected to do but are unable to accomplish. Areas of everyday living explored during the interview include self-care, productivity or leisure. http://www.thecopm.ca/learn/#steps_identify

- Rating importance

Once the therapist is confident that the client has identified the occupational performance problems experienced in everyday living, the second step of the COPM process is undertaken. In step two, the client is asked to rate the importance of each of the occupations to his/her life using a 10-point rating scale. http://www.thecopm.ca/learn/#steps_rate

- Selecting problem for scoring

In the third step of the COPM process, the client chooses up to five of the most important problems identified in step two to be addressed in intervention. The therapist enters the chosen problems and their importance ratings in the scoring section. This process serves as the basis for identifying intervention goals. http://www.thecopm.ca/learn/#steps_score

- Scoring performance and satisfaction

In step four, the client is asked to use a 10 point scale to rate their own level of performance and satisfaction with performance for each of the five identified problems. The therapist calculates an average COPM performance score and satisfaction score. These typically range between 1 and 10, where 1 indicates poor performance and low satisfaction, respectively, while 10 indicates very good performance and high satisfaction. http://www.thecopm.ca/learn/#steps_tally

- Client reassessment

The fifth and final step of the COPM process takes places at the completion of intervention or at a pre-determined time after intervention was initiated. The therapist again asks the client to self-rate performance and satisfaction for the problems addressed. The therapist then uses these scores to calculate the performance and satisfaction change scores.

http://www.thecopm.ca/learn/#steps_reassess

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- **Ollevier Aline:**
 - **MSc in Occupational Therapy; Research Coordinator at VIVES University of Applied Sciences in Bruges, Belgium**
- **Baetens Tina:**
 - **MSc, Ph.D. in Physical Therapy; Researcher at VIVES University of Applied Sciences in Bruges, Belgium**
- **Goderis Tania:**
 - **BSc in Physical Therapy, Rehabilitation; AZ Alma Hospital in Eeklo, Belgium**
 - **Vandewalle Marleen:**
 - **MSc in Physical Therapy, Rehabilitation; AZ Alma Hospital in Eeklo, Belgium**
- **Meijer Bastiaan:**
 - **BSc in Sport Management; Operational Manager at Nordic Health in Alkmaar, the Netherlands**
 - **Tol Jan:**
 - **CEO, Nordic Health in Alkmaar, the Netherlands**
 - **Schiettekatte Sylvie:**
- **BSc, R.N., MSc in Community Health; Ergonomist; Athlon S. Coop. in Mondragon, Spain**
 - **Várhelyi Edit:**
 - **CEO, David Gerincklinika in Budapest, Hungary**
 - **Benkovics Edit:**
 - **MSc in Physical Therapy; David Gerincklinika in Budapest, Hungary**
 - **Grannenfelt Lotta:**
 - **BSc Healthcare in Physiotherapy; Nordic Health in Helsinki, Finland**
 - **Parviainen Lauri:**
 - **M.D.; CEO, Nordic Health in Helsinki, Finland**

PATIENT HANDLING FOR CAREGIVERS, THE EULIFT PROJECT

Chronic low back pain is a common, long-lasting, and disabling condition with high societal costs. Caregivers are frequently exposed to elevated physical risk factors. Unfortunately, low back pain in caregivers is closely tied to patient handling techniques. Educating students with tools to implement in practice can be beneficial. eUlift provides full teaching material in patient handling for the future caregiver. All theoretical backgrounds and a detailed description in how to perform patient handling, supported with 3D animations. A train-the-trainer tool is developed for the responsible person of a ward that provides training to the caregivers. Development of the tool included different steps: (1) design a manual with all necessary background, (2) define learning outcomes, (3) integrate innovative didactics, (4) develop an innovative IT tool, (5) compose a train-the-trainer manual. The tool has been tested for usability in education and in practice over different European countries. Pilot testing in practice was a continuous approach to gain feedback and improve the content. Pilot testing of the train-the-trainer was evaluated cross country and revealed good results. The eUlift tool is finished, accessible online (for free) and ready to be implemented in practice. eUlift aims for a long-term solution from a self-regulated perspective and integrates an innovative approach, with a particular attention to detailed descriptions of the specific patient handling techniques, postures, and movements. We also explicitly focused on an academic approach with regard to training the caregivers (see the Train the trainer manual).

Key words: patient handling, the eUlift project, disability, assessment Level

Хронічний біль у попереку є поширеним, довготривалим захворюванням, що пов'язаний з високими соціальними витратами. Зменшення болю залежить від техніки роботи з пацієнтом. Для покращення навичок фізичної терапії та ерготерапії для студентів є розробленим та впровадженим навчальний посібник, що підготовлений завдяки проекту eUlift. У ньому подані усі теоретичні основи та докладний опис того, як здійснювати роботу з пацієнтами, важливою