

AGENDA ITEM 11

DISCUSSION ON WHETHER OCCUPATIONAL THERAPISTS WORKING IN PELVIC HEALTH CAN PERFORM INTERNAL EXAMINATIONS AND PROVIDE VARIOUS OTHER TREATMENTS.

Women's Experience Receiving OT for Pelvic Floor Dysfunction: A Case Series

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PURPOSE: Pelvic floor dysfunction (PFD) is a condition that affects one third of women, greatly impacting their quality of life. There is limited research on occupational therapy (OT) and pelvic floor health as pelvic floor therapy is a relatively new topic in the field of OT. Currently there is no research on women's perception of the OT intervention they received for PFD. It is important to understand the role and skills OT has to contribute to the field of pelvic floor health as PFD limits everyday occupations. The question this research seeks to answer is, 'What is the experience of women receiving occupational therapy for pelvic floor health issues?' The objective of this study is to explore the experiences of women who received OT for PFD.

DESIGN: This study was a qualitative, retrospective case series used to provide a detailed description of the experience and perspective of women who received OT for pelvic floor health conditions. Eligibility criteria included: ≥18 years old; biologically female participants; self-reported pelvic floor health issue; English speaking; completed OT intervention for PFD within the past two years. The researchers worked with a local pelvic floor occupational therapist (OTR), who owned her own private practice and focused on occupation-based therapy. Participants were recruited once they completed OT treatment with this OTR. The OTR encouraged current and past clients through social media and word of mouth to participate in the study. Once the clients showed interest, the OTR introduced potential participants to the lead interviewer via email and they were then screened for inclusion criteria via email.

METHOD: Four participants completed a semi-structured interview about their treatment and qualitative analyses were completed using inductive coding techniques. Participants' electronic medical records were reviewed. The Pelvic Floor Distress Inventory Questionnaire-20 (PFDI-20) was completed to assess changes in PFD symptoms and impact on quality of life (QoL).

RESULTS: Qualitatively, three main themes emerged from the data across participants: 1) Occupation-based therapy changed the course of women's ongoing journey with pelvic health, 2) Women experienced relief through discovering OT, and 3) Occupation-based therapy empowered women to be the experts of their own bodies. There were clinically significant changes in participants PFDI-20 scores indicating a decrease in PFD symptoms and impact of PFD symptoms on QoL following OT intervention.

CONCLUSION: In conclusion, it appears that OT interventions and being occupation-based may play an important role in positively impacting women's life with PFD. The women in this study experienced: empowerment to understand their bodies, a return to occupations they enjoyed, reduced PFD symptoms, and a changed journey with their pelvic health. This research is important in supporting and advocating for OT's role in women's health and pelvic floor health. More research is needed to investigate the mechanisms of what makes OT interventions effective in treating PFD.

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The Role of Occupational Therapists in Pelvic Health: An Interview With Lindsey Vestal

Robin Akselrud, OTD, OTR/L; and Lindsey Vestal, MS, OTR/L 08/01/2021

Akselrud, R., & Vestal, L. (2021). The role of occupational therapists in pelvic health: An interview with Lindsey Vestal. *SIS Quarterly Practice Connections*, 6(3), 12–14.

Pelvic health refers to bowel and bladder health, vaginal and uterine health, and sexual health, including muscles and structures in those areas. One in every three American women present with a pelvic health disorder, and the number of those diagnosed is projected to nearly double by 2050 (Wu, et al., 2019). Pelvic health disorders cost the United States health care system more than \$100 billion per year (National Institutes of Health, 2008). Not only are these health issues costly, but they also may affect the individual's mental health. Dysfunction in these parts of the body often take an emotional toll on the individual and can lead to depression, anxiety, and difficulty with intimacy and relationships (Khan, et al, 2013). Pelvic health issues are often associated with other medical conditions, such as obesity and diabetes from lack of activity (Khan et al., 2013). Research studies show that many female adolescents are unaware of their own pelvic anatomy and are unaware of the importance of pelvic health as they mature into adults (Hebert-Beirne et al., 2017). This lack of awareness can lead to chronic pelvic health conditions if issues are undiagnosed and untreated during adolescence (Hebert-Beirne et al., 2017).

Pelvic Floor Dysfunction

Pelvic floor dysfunction can affect women of all ages. Areas of dysfunction can include urinary issues (leaking, urgency, hesitation, retention, frequency), bowel issues (constipation, rectal pain or incontinence), and sexual issues (painful sex) (Sapsford, 2004). Weakness, overuse, or lack of coordination in the muscles of the pelvic floor, low abdominals, and lumbar spine can often lead to these pelvic floor symptoms.

Occupational Therapy as Part of the Team of Pelvic Health Professionals

Occupational therapy practitioners can be an important part of the team of health care professionals who work to promote pelvic health. In addition to difficulties with ADLs and IADLs, many clients experience loss of sleep due to nighttime toileting needs, thereby affecting their function and participation in work, play, and leisure activities throughout their day.

Evidence-Based Treatment Methods

There are several types of interventions that can be used with clients who present with a variety of pelvic floor deficits. Occupational therapy practitioners use a holistic, client-centered approach when treating their clients, focusing on the client's individual roles, habits, and occupations. Previously, intervention for pelvic floor dysfunction was focused on surgical and pharmaceutical interventions; however, current treatment has a behavioral focus—using strategies such as habit training, bowel/bladder retraining, diet/fluid regulations, and pelvic floor muscle training (Neuman et al., 2009). Research studies have shown that the most effective strategy to treat pelvic floor deficits is to use both biofeedback and traditional pelvic floor rehabilitation (i.e., strengthening and stretching the muscles of the pelvic floor) (Koh et al., 2008). Studies have also shown that mindfulness approaches, such as Mindfulness-Based Cognitive Therapy (MBCT), are successful at decreasing pain associated with pelvic floor deficits, and also combat anxiety associated with these deficits (Basson, 2012). OTs can assist their clients to improve both physically and psychologically through evidence-based, client-centered holistic treatment. To get a clear understanding of the daily experiences and career journey of an OT working in a pelvic health setting, I (first author, Robin Akselrud) chose to interview Lindsey Vestal, Founder of The Functional Pelvis, an in-home pelvic health practice in New York City. Here is a portion of our interview followed by a case example through her experience as an OT in this setting.

What advice would you give a therapist who wants to work in pelvic health?

1. ***Get a consistent mentor.*** While I had several very incredible mentors along the way, I would have benefitted from having a mentor consistently—having one person who I could contact about any question (however silly...no judgement!) so that I could continue to think through

how I could best serve my clients. I think we sometimes get to a place in our careers where we put a lot of external pressure on ourselves that we are supposed to know it all by now. I don't think this mindset serves us in pelvic health. Our clients' stories and experiences are complex, and it will always help the process best by assuming you don't know it all. Consider each client and each story with a fresh lens, and always remember that there is more to learn. Lean on a mentor to help your mindset grow.

2. *Take excellent continuing education, but know when to stop.* I put a lot of pressure on myself to take all my dream courses. I often thought, 'if only I could take one more ... one more.' Thank goodness that pelvic health is a field that demands being a professional who loves being a lifelong learner. But know when to take the plunge and start seeing clients. The best therapists in the field are the ones who learn with their clients, with their clients as their guides.
3. *Form a community of like-minded people in your area sooner rather than later.* I started a "pelvic floor study group" in New York City several years ago, and it continues to grow. We get together monthly, and the group consists of other pelvic floor therapists, childbirth educators, massage therapists, doulas, fitness pros, midwives, and OB/GYNs. This has served my growth in so many ways ... first, it's a great way to build your referral network. Second, it ensures continuing education! We present to each other on various topics (last meeting, we dove deep into diastasis recti) and I always learn so much! Third, it helps me feel less alone as a practitioner. I get to bounce ideas off my colleagues and grow in body, mind, and spirit. I have met some of my closest friends through growing this group. It's been amazing.

What is the difference between treatment by an OT and a Physical Therapist (PT) in this area of practice?

OTs work from a function first perspective. OTs, like PTs, are well versed in human movement and physiology, and there are often overlaps in our approaches. We even take the same courses to specialize in pelvic health. However, the difference comes from occupational therapy's foundational work in our background, and our mental health approach. PTs often focus on a symptom perspective, such as addressing where the discomfort/issue is happening, and work their way forward to address function. OTs typically focus on a function perspective, such as addressing the tasks, movements, and occupations that are affected by the symptoms. They determine how the symptoms are influencing life roles, emotional wellness, and quality of life. Pelvic health and mental health are inextricably linked. A biopsychosocial approach (one that addresses the physical, emotional, psychological, and social wellness) of an individual is such a holistic way to address pelvic floor function. It is one where the client feels seen and heard and we are their guide in their recovery. Pelvic health is much more complex than just the physical symptoms. As occupational therapy practitioners working in this area of practice it's important to

view the client in a holistic manner, addressing both their physical and mental health as it is affected by pelvic floor dysfunction.

An OT's Role In Pelvic Health Through a Practitioner's Lens: A Case Example

Elisabeth was 8 weeks postpartum. She was referred to me (Occupational Therapist Lindsey Vestal) by her midwife. Elisabeth had a long labor of around 38 hours. She pushed for around 2.5 hours and had a natural tear that was about 2 degrees. This is the most common tear during childbirth, and it extends through the skin and into the muscular tissue of the vagina and perineum. She was experiencing urinary frequency—every hour or so. She was leaking urine when she coughed, and she was straining excessively during bowel movements. She stopped visiting with friends, planned her errands around fluid intake, and overall withdrew from activities of leisure. She had not tried having sex with her partner yet and was anxious about resuming intimacy. Elisabeth enjoyed spinning, swimming, and using the elliptical, and she was apologetic for not resuming these exercises.

Elisabeth's discomfort around caring for her baby was tied to the lack of sleep she was getting due to her baby's sleep schedule. We talked about keeping open communication with her partner to share responsibilities, and other topics such as co-sleeping with her baby to maximize sleep hygiene. Otherwise, a routine (as much as one can have one at 8 weeks) had been established. She was nursing successfully. She was comfortable with her added role of becoming a mother, as she was the oldest of a large family. Her goals included being interested in being intimate with her husband again ("hoping it didn't hurt"), not leaking urine, and being able to exercise again.

I listened to her birth story with compassion and empathy and was physically, mentally, and emotionally present for her. I have noticed many clients start repeating some of the things most people ask them about (e.g., how long was labor, did they get an epidural, how long did they push). I see them going into "replay mode" and not really telling the story as perhaps they may want to. If I notice this, I gently ask if there is anything else about their birth they want to mention—the emotional story. Perhaps the fact that the birth didn't go as planned, or that Elisabeth really thought a c-section was going to happen, or that she didn't have advocacy when a student anesthesiologist performed the epidural even when she said she would prefer someone else—things that are often untold because we think others wouldn't want to hear them. Talking with me certainly helped Elisabeth, but I referred her out to a mental health specialist to specifically focus on her traumatic experiences. This absolutely helped her in our sessions as well. These are the things that are traumatic to our clients, and I think having a conversation around them can be so healing for them. I encourage holding space for that.

Elisabeth was anxious about her pelvic floor. I introduced the role of the diaphragm and the breath with the pelvic floor to help Elisabeth develop her body literacy around this topic. I wove in relevant statistics, such as more than 25 million people in the United States (National Association for Continence, 2018) experience urinary incontinence. These statistics help ease clients from feeling the burden that they are the only one to have experienced these things, which is common.

I performed a postural assessment on Elisabeth, which assesses functional tasks like standing at a counter, picking something off the floor, squatting, reaching, rotating, and walking. I then checked her diaphragm, abdominal wall, hips, inner thighs, and glutes. We reviewed perineal care and scar massage techniques.

Elisabeth was hypertonic (i.e., overactive) on her right side (where she tore) and was hypotonic on her left side. She had poor breathing coordination, could not elongate her pelvic floor with the inhale, and was contracting more with her rectum than with her clitoral muscles. She also had limited ribcage mobility, so we did some gentle things that were also downregulating for her nervous system, such as thread the needle, and some gentle foam roller exercises. I had her check in with her breathing and her pelvic floor response throughout these exercises, mentioning she may not always feel it because this was such a new sensation for her. After discussing how our sessions would build on one another, we set the first session goal to improve her proprioception of her pelvic floor coordination and movement.

I also revisited the urinary frequency that Elisabeth reported. I wanted Elisabeth to pay attention to the cues her bladder was sending her that week. Did she remember what it felt like for her bladder to have an urge? How about to be full? Again, we were working on body literacy and interoception. In terms of the leaking with coughing, this came back to coordination, and since I knew Elisabeth was both hypo and hypertonic, we started with connecting via the breath. We reviewed optimal toileting posture and how the breath can help relax the process. Another opportunity to address pelvic floor full range of motion daily was by lifting her baby up on an exhale (when the core is stabilized), incorporating good posture with feeding her baby, pushing her stroller, and practicing optimal sitting posture.

I also wanted to make sure to touch on Elisabeth's fear of painful intimacy. I shared with her what to expect in terms of norms—less and less painful, the importance of healthy lubricants, being open to sex being different, and exploring her sexuality by herself first.

We spent some time going over how time and space for healing postpartum could help her on her journey to getting back to her preferred exercises, and that waiting for these activities didn't

mean she was going to get behind. We worked on a gradual return to exercise, which began with gentle walks in her neighborhood and swimming. I told her that we would gradually get her back to all the things she loved but wanted to give her a rationale to consider how waiting and creating a thoughtful re-entry was beneficial, versus thinking she “missed the boat” and was not going to get fit. Eventually, Elisabeth was able to resume all her chosen ADLs and stated, that she had a much more profound understanding of her body and its capacity to heal.

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Lindsey Vestal, MS, OTR/L, is the owner and rehab director of The Functional Pelvis in NYC + Paris. She graduated from NYU in 2011 and is the founder of The Functional Pelvis, the first in-home pelvic health practice in New York City run by an occupational therapist. Lindsey has helped thousands of people overcome chronic pelvic health challenges like incontinence and pelvic pain. Her goal is to empower women and men to listen to the wisdom of their own bodies—without resorting to invasive surgeries or prescription drugs—so they can heal and get back to enjoying life again. She also offers AOTA-approved CEU courses such as *OT Pioneers: Intro to Pelvic Floor Therapy for Occupational Therapists* and *Private Pay MBA*.

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Addressing Pelvic Pain in Older Women

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Scott, A., Digwood, K., Teslow, R., & Elrod-Bloom, A. (2021). Addressing pelvic pain in older women. *SIS Quarterly Practice Connections*, 6(3), 23–26.

Twenty five percent of women in the U.S. are affected by a pelvic floor disorder (PFD; Wu et al., 2014). The prevalence of a PFD increases with age, and more than 40% of women ages 60–79 and 50% of women 80 years of age and older are affected (National Institutes of Health [NIH], 2008). The NIH has not published more recent statistics on the prevalence of PFD in older women. PFD is an umbrella term that most commonly includes pelvic pain and urinary incontinence. *Chronic pelvic pain* is defined as persistent, noncyclic pain perceived to be in structures related to the pelvis (Speer et al., 2016). Women experiencing pelvic pain may have difficulty or reduced desire to engage in previously meaningful occupations. For this reason, occupational therapists are important health professionals to evaluate and treat chronic pelvic pain among older women. This article explores a comprehensive occupational therapy plan of care for pelvic pain in older women.

The Role of Occupational Therapy In Addressing Chronic Pelvic Pain

Occupational therapy practitioners have the knowledge to address pelvic pain in a holistic way through recognizing the physical and psychosocial implications of pelvic floor dysfunction. Using the *Occupational Therapy Practice Framework: Domain and Process* (4th ed.; American Occupational Therapy Association [AOTA], 2020b), occupational therapy practitioners can identify supports and barriers to occupational participation and performance to provide

identify supports and barriers to occupational participation and performance to provide interventions that focus on client factors, performance skills, and performance patterns. Pelvic pain can affect occupations such as work, self-care, leisure, and engagement in sexual intimacy, which may contribute to anxiety, depression, and social isolation, and impact quality of life (Siqueira-Campos et al., 2019). Studies have shown rates of depression range from 26% to 52% in clients with chronic pelvic pain, compared with 5% to 10% in the general population (Till et al., 2019). Rates of anxiety are also elevated (39% to 73%) when compared with 12% in the general population (Till et al., 2019). Anxiety, fear, and embarrassment may be reasons that some women experiencing chronic pelvic pain are reluctant to discuss their symptoms with their medical provider.

Evaluation for Chronic Pelvic Pain

An occupational therapy evaluation for an older woman experiencing chronic pelvic pain should begin with creating an occupational profile (AOTA, 2020a). Understanding the depth and breadth of the impact that the condition has on the client's occupational habits and routines as well as cultural, social, emotional, and physical well-being is key to developing a comprehensive plan of care (Ayorinde et al., 2015). In addition to the occupational profile, pain scales and questionnaires are useful and reliable tools to assess pain intensity. Questionnaires allow for the distinction between nociceptive and neuropathic pain in clients presenting with more complex painful syndromes (Passavanti et al., 2017). Some common questionnaires are the Pelvic Pain Impact Questionnaire (Chalmers et al., 2017) and the Visual-Analog Pain Scale (Poli-Neto et al., 2018).

Occupational Therapy Interventions for Chronic Pelvic Pain

A variety of interventions can be used to address chronic pelvic pain. The following intervention techniques are often completed as preparatory interventions to be used in conjunction with other strategies that focus on restoration, compensation, and/or adaptation of meaningful occupation-based activities to promote performance. Restoration strategies focus on regaining the exact performance skill, performance pattern, ADL, or occupation that is being addressed. An example of this type of intervention strategy could be using pelvic floor muscle exercises to increase strength and awareness of the pelvic floor to facilitate bladder management, allowing the person to participate in valued activities. Compensation strategies emphasize client education for alternative habits based on activity analysis. An example of a compensatory strategy could be using deep breathing relaxation techniques to release tension and reduce anxiety to decrease pain related to sexual intimacy, leading to a more satisfying relationship. Strategies focused on adaptation are based on factors outside of the client such as the environment. An adaptation strategy example could be a client using a wedge cushion to modify pelvic positioning during

strategy, examples include teaching a range of pelvic floor exercises, pelvic floor strengthening during sexual intimacy to decrease pelvic pain, helping the client to achieve their goal. By addressing the underlying etiology causing the deficits in occupational performance, practitioners can address the root causes, with the goal of facilitating participation.

Myofascial release (MFR) is an intervention that operates on the premise that trauma or inflammation of the fascia creates undue tension on the surrounding tissues and structures, resulting in pain or loss of mobility (Barnes, n.d.). MFR is a manual technique that releases the tension through manual manipulation of the fascia (Barnes, n.d.). Common symptom-based interventions may include treatment of trigger points using MFR, neural glides, pain neuroscience education, graded exposure/activity, and cognitive functional therapy (Chou et al., 2012). MFR requires advanced training to become proficient in the intervention technique.

Often biofeedback is used to increase a client's awareness of bodily functions during an ADL task such as bladder management. Biofeedback is an interdisciplinary treatment, based on self-control of physiological processes in the body. The goal is to improve muscle control in the pelvic floor and to promote muscle relaxation (Morin et al., 2017). Occupational therapy practitioners need certification to use this approach with clients with pelvic floor dysfunction. Biofeedback is typically done using surface electromyography, which is performed using a specialized piece of equipment that measures the output of a muscle using surface electrodes paired with visual and auditory feedback to offer the client reinforcement of proper technique (Morin et al., 2017). This intervention is most effective when paired with a functional task such as toileting to improve overall quality of life (Rafiepoor et al., 2017). In a recent systematic review, the evidence supported pairing biofeedback for pelvic pain management with cognitive behavior therapy (CBT), pain neuroscience education (PNE), pelvic floor muscle exercise (PFME), and lifestyle modifications to improve client self-efficacy and quality of life (Wagner et al., 2021).

CBT has been shown to be an effective intervention for chronic pain and depression (Till et al., 2019). The governing principle of CBT is to increase the client's awareness of the thoughts and behaviors that affect pain and occupational engagement. This allows clients to adjust these thoughts and behaviors. Altering the client's thoughts and behaviors can create a positive impact on autonomic arousal, graded activity and pacing, sleep hygiene, problem-solving strategies, coping skills, and interpersonal skills. CBT typically involves increasing self-awareness, compensatory strategies such as self-pacing, and developing coping mechanisms (Till et al., 2019).

In addition to CBT, PNE may be effective in addressing pelvic pain. This intervention consists of client education detailing the neurobiology and neurophysiology of pain and nervous system pain

processing. Pain chronicity may not be caused by unhealthy or dysfunctional tissues, but by brain plasticity leading to hyper-excitability of the central nervous system. The goal of this method is to change a client's perception of pain. PNE aids clients' understanding that pain may not correctly represent the health of tissue but may be because of extra-sensitive nerves (Louw et al., 2011). PNE can be used in conjunction with the various restoration, compensation, and adaptation strategies previously mentioned to break down movement-related pain memories to affect pain, disability, anxiety, and stress that impact numerous ADLs. By focusing on reducing the psychosocial impact of pain, the systematic review found positive effects on overall occupational performance (Ghaderi et al., 2019).

Case Example

A 65-year-old woman presented with chronic pelvic pain that she had experienced for the last 5 years. She reported that the pain had worsened over time and was affecting her ability to engage in daily occupations, as well as her roles as a wife and employee. The client verbalized feelings of anxiety and depression because of her decline in ADLs and IADLs. The client was previously assessed by her OB-GYN (who referred her to occupational therapy), and no infections or other significant medical issues were present. During the initial occupational therapy session, the occupational therapist (OT) completed an initial evaluation that included developing an occupational profile (AOTA, 2020a). During the interview, the OT noted that the client was experiencing pelvic pain as well as depression and anxiety related to her pain. Evaluation of the client's performance skills and patterns revealed an inability to relax the pelvic floor muscles, which affected her ability to engage in bicycle riding and sexual intimacy.

A plan of care was developed to address the physical and psychosocial needs of the client. The OT determined that a CBT approach incorporating PNE would be the best way to address the client's pain and reduce anxiety related to occupational engagement in leisure activities and sexual intimacy. PNE was used to educate the client on perceptions of chronic pain, and CBT was used to identify patterns in daily routines that exacerbated the pain and to modify those daily routines as a means of promoting occupational engagement.

As the client progressed, PFMEs (see Table 1) and biofeedback were incorporated. The PFME facilitated a balance of strength between agonist and antagonist muscles and aided in increased awareness of the pelvic floor muscles. Education and relaxation techniques using deep breathing were a central focus of interventions during each session. Education provided before discharge consisted of training on a preparatory home exercise program as well as compensatory strategies such as deep breathing exercises and relaxation techniques during activities that increased pelvic

pain. At the conclusion of therapy, pain was decreased, and the client demonstrated increased occupational engagement because of less pain and reduced anxiety.

Table 1. Pelvic Floor Muscle Exercises

Exercise	Instructions
Quick Flick	Quick contract and release of the pelvic floor muscles. Client tightens the urethral or vaginal and rectal opening and then releases; this is a quick contraction, then a release. The contraction should be quick and forceful. Gluteal abdominal, adductors, and obturator internus muscles are relaxed during this exercise.
Reverse Kegel	Can be completed while seated, standing, or lying supine with knees bent. Breathe deeply and bring awareness to pelvic floor. The muscles of the pelvic floor should relax and drop down with inhalation. Hold the "drop" for 5 seconds, then relax for 5 seconds.
Piriformis Stretch	In supine position with knees bent and feet on ground, partially cross legs by placing left ankle on top of right knee. Place left hand on left knee. Gently push left knee away from you until you feel a gentle stretch. Hold the stretch for 20 to 30 seconds. Repeat using right ankle on top of left knee.

Resources

For occupational therapy practitioners to be proficient in addressing pelvic pain in older women, advanced training is often needed. Trainings listed in Table 2 are specific to occupational therapy.

Table 2. Training Resources

Certification or Training	Description	Website
Certification in Pelvic Floor Rehabilitation: A Guide for Occupational Therapists	Provides an overview of the pelvic floor, occupational therapy's role, interventions, and certification options.	https://bit.ly/2OGhGUH
How to Become a Pelvic Health OT	Blog posts that describe the path to being involved in pelvic rehab as an occupational therapist.	https://bit.ly/3sg1omj
Cognitive Behavioral	Several levels of certification that	https://bit.ly/3uDOxsC

Therapy	<p>occupational therapists are eligible to obtain based on experience and additional criteria:</p> <p>Certified Cognitive–Behavioral Therapist (CCBT)</p> <p>Diplomate in Cognitive–Behavioral Therapy (DCBT)</p>		
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Conclusion

Occupational therapy practitioners can create an occupational profile for clients to address the effects associated with PFD in a holistic way to improve overall quality of life. Addressing the physical and psychosocial needs of older women with chronic pelvic pain is essential for creating lasting results and fostering engagement in meaningful occupations.

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Occupational Therapy's Role in the Treatment of Pelvic Organ Prolapse

Julie Blacker, MS, OTR/L; Kelsey Mathias, OTR/L, BCB-PMD; Tiffany Lee, MA, OTR, BCB-PMD, PRPC; Hyland Peek, MOT, OTR/L; and Mara Podvey, PhD, OTR 11/01/2020

Blacker, J., Mathias, K., Lee, T., Peek, H., & Podvey, M. (2020). Occupational therapy's role in the treatment of pelvic organ prolapse. *SIS Quarterly Practice Connections*, 5(4), 27–29.

Occupational therapy practitioners (OTPs) advocate for population health and wellness outcomes (Hammell, 2015), including supporting women's health (Podvey & Kern, 2018). They can fill gaps in available services across the lifespan, from healthy transitions to motherhood to supporting older women experiencing occupational isolation and physical changes. This article describes the role of OTPs around pelvic organ prolapse (POP), a common condition in women with pelvic floor (PF) disorders.

What is POP?

The PF consists of three layers of superficial and deep muscles, and a complex system of ligaments and pelvic bone structures (Vopni, 2014). The PF represents the bottom of the "core" muscles. Other muscles that comprise the core include the diaphragm, transverse abdominis, and multifidus muscles. The PF supports pelvic organs and allows force from different directions, offers stability and postural control, supports breathing, allows for sexual function and control of bladder and bowel sphincters, and provides drainage of blood and lymphatic fluid (Saunders, 2017; Vopni, 2014). Risk factors for PF dysfunction include:

- Pregnancy and childbirth
- Aging and related conditions (e.g., decreased estrogen, elasticity)
- Health conditions (e.g., obesity, chronic constipation/cough, increased pelvic pressure,

nerve/muscle diseases, joint/connective tissue disorders)

- Behaviors (e.g., smoking, repetitive heavy lifting, excessive caffeine consumption) (Howard & Makhlof, 2016; Saunders, 2017; Vopni, 2014)

POP, a common type of PF dysfunction, is a weakening or disruption of the PF system, resulting in organs typically supported sagging into the vaginal canal (see Table 1 for types of POP). POP is typically evaluated by a gynecologist, urogynecologist, or PF therapist with advanced training through pelvic exam in supine and standing positions. More than 50% of women who gave birth at least once will experience POP during their lifetime (Saunders, 2017; Vopni, 2014). Pain, discomfort, urinary/fecal incontinence, difficulty emptying bladder/bowels, constipation, emotional distress, and poor body image are some symptoms and reactions associated with POP.

Table 1. Types of Pelvic Organ Prolapse

Type of Prolapse	Organs Involved
Cystocele	Bladder
Enterocoele	Small Intestine
Rectocele	Rectum
Hysterocele	Uterus
Vaginal Vault	Upper vaginal wall or uterus

POP frequently leads to activity limitations, which can considerably affect quality of life, including discomfort leaving home and decreased participation in work, self-care, leisure, sexual activity, and many activities associated with motherhood (Saunders, 2017). Prolapse symptoms can interfere with one's ability to maintain a healthy lifestyle, remain independent, and participate in fulfilling relationships. POP is not an individual issue; disruption of occupations can affect entire family structures, workplaces, and communities.

Because of their sensitive nature, clients may be reluctant to discuss POP symptoms with anyone, so OTPs may identify potential POP symptoms as they develop a client's occupational profile, or during interventions for other issues. OTPs can explain that symptoms causing occupational disruption (e.g., incontinence, pelvic pain, difficulty with elimination) are common but not normal, and can be addressed after a pelvic evaluation by a qualified professional (e.g., gynecologist,

urogynecologist) determines the degree and specific location of the POP, and the organs affected. Treatment options include surgical and non-surgical (e.g., therapeutic) interventions. Surgery relieves symptoms, but recurrence rate is as high as 30% (Chung & Kim, 2018). Alternatively, many women choose conservative treatment using a *pessary*, a device placed into the vagina temporarily supporting the pelvic organs and relieving symptoms for improvements in quality of life.

Occupational Therapy's Role In POP Management

The high prevalence of POP means OTPs working with women will likely encounter clients with POP in traditional practice areas. All OTPs can improve POP outcomes by providing basic interventions, client education, and referrals. Occupational therapy is a natural fit for minimizing the effects of POP on daily occupations by incorporating interventions that promote healing and well-being, and prevent further harm. In addition to the physical management (explained later in this article), POP is an emotional, participation, and physical barrier. Understanding habits, routines, and lifestyles with POP is critical for promoting best outcomes for occupational performance and participation (Due et al., 2016). OTPs can create a global treatment plan considering all aspects of a client's life (Sabel & Gallagher, 2015) including addressing daily life implications, adaptations, psychological effects, social influences, sexual difficulties, and hygienic effects of prolapse.

Understanding habits, routines, and lifestyles supports promoting best outcomes for occupational performance and participation after POP. For example, new mothers may present with POP, but still need to care for their baby and other children while managing lift restrictions. Considering necessary occupations for individual clients is important while simultaneously promoting mental health and prevention of other comorbidities, including back pain and carpal tunnel syndrome.

All OTPs can:

- Teach clients to correctly perform Kegel exercises, including contraction and release, to develop a strong, flexible PF that supports the pelvic organs (Evans, 2019)
- Provide education around diet (e.g., increase fiber/fluid intake) to decrease constipation and strain during voiding, reducing the incidence and preventing worsening of POP (Due et al., 2016)
- Improve poor body mechanics and compensations that may exacerbate POP symptoms by means of ergonomic and core strength training (Vopni, 2014)
- Teach self-regulation techniques, including progressive muscle relaxation and mindfulness, to decrease anxiety while improving body awareness (Goodman et al. 2019)

decrease anxiety while improving body awareness (Goodman et al., 2019)

- Use environmental modification strategies to reduce lifting, straining, or pulling, which can aggravate POP symptoms (Podvey & Kern, 2018)
- Train clients to decrease intra-abdominal pressure by breathing/exhaling with movement or effort (e.g., picking up a baby; Due et al., 2016)

Advanced Evidence-Based Interventions for POP

Some occupational therapists (OTs) and physical therapists (PTs) may choose to complete advanced continuing education courses to become PFOTs or PFPTs who evaluate and treat clients specifically for PF dysfunction, including POP. Advanced education and certification in PF therapy are also available for interested PFOTs.

PFOTs use individualized PF therapy to reduce POP symptoms and increase quality of life by improving PF muscle strength and endurance, resting tone, awareness of muscle relaxation, and awareness of body posture during functional activities (Maxwell et al., 2017). PF therapy strategies vary depending upon the practitioner, their discipline, and their specific training. PFOTs can help clients make behavioral changes when participating in ADLs/IADLs by analyzing respiration and posture to ensure effective diaphragmatic breathing and coordination of PF muscles. PFOTs teach clients to engage the transverse abdominal muscles during movements, including ADL and IADL participation, decreasing concerns around prolapse.

Pelvic floor muscle training (PFMT) is an effective type of PF therapy that is more cost effective than surgery (Maxwell, et al., 2017). Clients receiving PFMT have fewer prolapse, vaginal, bladder, and rectal symptoms and report feeling improvements in their prolapse (Li et al., 2016). PFMT may include strengthening exercises and surface electromyography biofeedback, a form of strengthening and changing muscle function through biofeedback. When PFMT is combined with lifestyle modification (e.g., behavioral changes to reduce pressure on PF), clients perceived global improvements and reduction of prolapse symptoms (Due et al., 2016).

Other PF therapy interventions include splinting to evacuate bowels, an approach that involves applying pressure externally on the perineum or internally through the vagina, pushing against the rectum; double voiding; constipation management; effective lifting techniques including “the knack,” which is an elevation of the PF with movement to engage PF muscles; and avoidance of intra-abdominal pressure by breathing/exhaling with movement (Trowbridge and Fenner, 2005).

Case Example

Max was a 31-year-old female who had been diagnosed with POP. She was referred to a PFOT for bladder

Mary was a 51-year-old stay-at-home mother of three who was referred to a PFOT for bladder prolapse, and urinary and fecal incontinence. Before her referral, Mary's symptoms gradually worsened. Her fear of having her "bladder fall out" and having an incontinent episode in public had caused her to become homebound. Mary expressed concerns that her marriage would suffer because she was concerned about intercourse exacerbating her prolapse. She expressed feelings of hopelessness, low self-esteem, and difficulty balancing her roles as mother, wife, and homemaker. After discussing her concerns with the PFOT, Mary's goals for treatment were to reduce episodes of urinary and fecal incontinence, improve self-efficacy with her life roles, and be able to complete ADLs and IADLs without increased POP symptoms. The PFOT addressed Mary's fears by educating her on PF anatomy and risks associated with having a prolapse; the role of diet and fluids in urinary frequency, constipation, and straining; and proper toileting postures to reduce straining and assist with full elimination. The PFOT trained Mary to use good body mechanics when picking up her kids to reduce pelvic pressure. Mary learned to use lubricants, increase time with foreplay, and experiment with positions to engage in pain-free intercourse. She also learned how to breathe while allowing her ribs and belly to expand while inhaling. This technique helped relax her PF muscles and reduce symptoms of prolapse. The PFOT developed a PF strengthening program to address Mary's urine and stool leakage. The PFOT taught Mary how to perform PF muscle contraction without using abdominal muscles, and relaxation using surface electromyography biofeedback. As Mary's PF muscle control improved, the PFOT taught her to inhibit bladder urges, particularly when she was in the community, and how to relax her PF muscles during a bowel movement. Through therapy, Mary reported improved confidence in her own body as her bladder and bowel patterns became more regular and leakage reduced. She reported a reduction in prolapse symptoms and improved self-esteem as she regained control of life's most basic functions. Mary's participation in community activities resumed, including a weekly moms' group, grocery shopping, and attending church. Mary reported full participation in her roles as mother, wife, and homemaker.

Acknowledgement

The authors acknowledge Emily Browder-Bohall for her work on a draft of this article.

Resources for POP

- <https://www.pelvicorganprolapsesupport.org/>—Non-profit organization providing support, guidance and references for treatment of POP
- <https://www.acog.org/Patients/Patient-Education-Videos/Pelvic-Organ-Prolapse?IsMobileSet=false>—Videos explain differences between the types of prolapses that women experience, as well as pessary use

- <http://www.ics.org>—International Continence Society
- <https://www.voicesforpfd.org/resources/helpful-organizations/>—Comprehensive list of resources for POP management

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AGENDA ITEM 14

**ADMINISTRATIVE COMMITTEE RECOMMENDATION REGARDING THE
MAXIMUM NUMBER OF STUDENTS COMPLETING A DOCTORAL
CAPSTONE EXPERIENCE THAT CAN BE SUPERVISED BY AN OT/OTA.**



ADMINISTRATIVE COMMITTEE MEETING HIGHLIGHTS

August 18, 2023

Woodbury University

Bowman Conference Center

7500 N Glenoaks Blvd, Burbank, CA 91504

1. Meeting was called to order, roll was called, and a quorum was established.
2. Board President and Committee Chair Denise Miller welcomed everyone in attendance and thanked Woodbury University for hosting the meeting.
3. Public members that were attendance introduced themselves, including:
 - Board Member Sharon Pavlovich was in attendance as a member of the public.
 - Penny Slack, Doctoral Capstone Coordinator for Loma Linda University.
 - Heather Kitching, MSOT Fieldwork Coordinator for CSU, Dominguez Hills (CSUDH).
 - Eva Celeste, Entry Level OTD student at CSUDH.

Board President and Committee Chair Denise Miller invited Ms. Slack to share the comments she had submitted. Ms. Slack suggested the committee define 'clinical' as providing direct patient care in a doctoral capstone and highlighted an example. Ms. Slack pointed out that a doctoral student may complete a capstone in pelvic health, yet not provide hands-on, direct patient care.

In reference to language previously discussed by the Board, Ms. Slack clarified that while occupational therapy assistants can supervise an occupational therapist completing a non-clinical experience, they cannot supervise an occupational therapist completing a clinical doctoral capstone experience under the Guidelines of the Accreditation Council on Occupational Therapy Education (ACOTE).

Dialogue continued regarding the use of mentorship in the ACOTE Guidelines and how mentorship varied from supervision.

In reference to supervising a maximum of three Level I and II fieldwork students at any one time, Heather Kitching shared that at CSUDH they might send out a group of eight students to a psycho-social setting and explained how pairing groups of two students benefitted the students and the clinical supervisor.

Board President and Committee Chair Denise Miller pointed out that while the Committee and Board weren't trying to make the supervision process more difficult,

especially given the challenges the programs experienced in placing students in their required fieldworks, the protection of the consumer was still the Board's mandate.

Discussion ensued regarding the maximum number students that can be safely supervised, the use of a 'laboratory' setting, and the flexibility afforded the education programs under the ACOTE Guidelines. Further discussion surrounded the fact that academia was also considered a practice-setting. An example of fifteen Level I fieldwork students was provided, which is allowed under the ACOTE Guidelines. Everyone acknowledged that acuity was key in deciding the maximum number of students.

The Committee agreed that addressing the increase in the number of Level I students that could be supervised in a faculty-led fieldwork, needed to be addressed, and would recommend that to the Board.

4. Review and vote on approval of the March 22, 2023, Committee meeting minutes.

The meeting minutes were not available.

5. Consideration and possible recommendation to the Board on the maximum number of students completing a *non-clinical* entry-level doctoral capstone that can be supervised by an occupational therapist who is concurrently supervising occupational therapy assistants, limited permit holders or students completing their fieldwork.

Given the earlier comments, the Committee suggested for clarity, that occupational therapist supervision of a non-clinical capstone experience be specified by the capstone areas listed in the ACOTE Guidelines with no maximum number of students specified.

6. Consideration and possible recommendation to the Board on the maximum number of students completing a *clinical* entry-level doctoral capstone that can be supervised by an occupational therapist who is concurrently supervising occupational therapy assistants, limited permit holders or students completing their fieldwork.

Given the Board's discussion at its May meeting surrounding a total of total of three Level I fieldwork students, Level II fieldwork students, Limited Permit holders, or Doctoral capstone students completing a clinical capstone experience, as being the most that an occupational therapist should supervise, the Committee thought it important to provide more specificity. Thus, they discussed the importance of adding further language to 'clinical,' including 'direct patient care.'

7. Consideration and possible recommendation to the Board on the maximum number of students completing a *non-clinical* entry-level doctoral capstone that can be supervised by an occupational therapy assistant who is concurrently supervising occupational therapy assistants, limited permit holders or students completing their fieldwork.

The Committee suggested, for clarity, to add a new subsection acknowledging that occupational therapy assistants (OTAs) can supervise doctoral capstone students completing a non-clinical capstone as allowed under ACOTE Guidelines.

8. Consideration and possible recommendation to the Board on the maximum number of students completing a *clinical* entry-level doctoral capstone that can be supervised by an occupational therapy assistant who is concurrently supervising occupational therapy assistants, limited permit holders or students completing their fieldwork.

To be consistent with ACOTE Guidelines, the Committee agreed to recommend to the Board, that language not be included to authorize OTAs to supervise an OT completing a clinical doctoral capstone experience.

9. New suggested agenda items for a future meeting.

The Committee agreed that, subject to the Board's action at its August meeting relating to recommended edits to CCR Section 4181, the Committee may need to meet again to discuss possible edits to CCR Section 4180, to ensure continuity and alignment in language relating to supervision.

Public Comment received via email

Hello, CBOT Administrative Committee:

I would like to share my following comments for your consideration on the agenda items to be discussed at the Administrative Committee Meeting this Friday (8/18/23). I apologize for not being able to attend the meeting in person but would highly appreciate if my comments could be taken into consideration at the meeting. I look forward to hearing any feedback and/or any outcome of the meeting. Thank you!

E.H, Ph.D., OTR/L

Comments on OTD Capstone Supervision (Capstone Site Mentors)

OTD capstone experience is largely different from OT fieldwork I & II in many perspectives. In addition, ACOTE allows an OTD capstone experience to focus on a wide variety of areas: clinical practice skills, research skills, administration, leadership, program and policy development, advocacy, education, and theory development (ACOTE, 2018). It is practically undue, or challenging, to say the least, to generalize “one maximum number” that mixes in with FWI, FWII and capstone students.

1. OTD capstone experience is more of a self-directed learning process wherein a site mentor typically is not required to offer substantial guidance or close supervision as one would do as a fieldwork educator. The key concern is how a site mentor can adequately support a capstone student in achieving their self-initiated capstone learning objectives at the site, rather than how a site mentor should abide by the type and quantity of supervision allowed or recommended by the CBOT regulation. In addition, besides a site mentor, an OTD capstone student is required to have a capstone faculty committee (3 or more members) on board to provide necessary support throughout the student’s capstone experience. This significantly helps curtail the possibility of a site mentor’s overcommitment to capstone supervision/guidance on top of FW students. A certain degree of autonomy and deliberation should be bestowed upon the main players (capstone coordinator, capstone committee, site mentor and student) of OTD capstone who are believed to be capable of making the best decision for the proposed doctoral capstone.

2. Per ACOTE, site mentors selected for overseeing OTD capstone experience are not limited to licensed OT practitioners. If the CBOT's jurisdiction does not reach extensively to non-OT site mentors, the regulations in this regard will appear selectively effective to mentors who are OT practitioners, but not to all. Let's take a scenario: if CBOT ended up setting a cap of 4 supervisees (regardless of FW-I, FW-II or capstone). As such, several capstone students (potentially from different schools) chose to implement their capstone programs at a community-based adult service (CBAS) site. Two potential local CBAS sites have been identified. Site A has an OTR readily available to take one more student only and Site B has no OT but an RN available to assume the mentor role. Wouldn't such CBOT regulation present a loophole for programs/students to purposefully select a site with a site mentor that is readily more available and less bound by the regulation?

3. With the wide varieties of OTD capstone options as suggested by ACOTE, it is unreasonable to generate a one-size-fits-all cap that limits the number of supervisees including capstone students an OT can take. Let's take a scenario. An OTR and the former OTAC president working at a VA hospital is being asked by several OTD students (potentially from different schools) to serve as the site mentor for their advocacy and policy development projects for the client population due to her renowned political experience and connections with state legislators. Collaboratively, all these proposed capstone projects can be well organized and guided by such an OTR in a collective manner without relying on much of her close supervision or hands-on guidance for each individual capstone student. Indeed, there are special capstone options (e.g., leadership, advocacy, policy development, theory testing, research in a specific area) wherein a limited number of potential OT site mentors (experts) are to be recognized and approached for taking on such a role. Speculating upon these experts' capacity for supporting capstone students by a calibrated/formulated "number" may appear micromanaging and disrespectful of professional expertise in our field. Again, a certain degree of autonomy and deliberation should be bestowed upon these experts of our profession. They know better how to support doctoral capstone students in the area of their expertise (and within the level of their capacity) than a calibrated/formulated "number".

4. For capstone experiences that involve clinical practice with or service delivery to clients/participants, our CSUDH OTD program (perhaps many other programs as well) strictly prohibits such service from incurring revenue or reimbursement for the site or the site mentor, namely; all services are set to be "pro bono" in nature for the current or future clients of the site and such

services are additional/optional to whatsoever routine services those clients receive through their usual payment sources. I do not foresee a possible incentive for an OT site mentor to acquire more OTD capstone students than the degree to which their time and capacity can cover. In addition, a policy statement in our OTD Capstone Handbook goes that “The level of support or assistance an OTD capstone student may request from the site staff (including site mentor) must be reasonable and not affecting their routine job duty.” This could be seen as another significant difference from FW-II.

In a nutshell, I personally do not support the idea of having an overall cap that mixes in with limited permit holders and FWI, FWII, and capstone students. Due to the distinct nature and the wide varieties of options in OTD capstone, it should not be simply regulated and quantified along with other types and parameters of OT supervision. I believe in the capacity of the capstone main players (capstone coordinator, capstone committee, site mentor and student) for properly managing each of their unique OTD doctoral capstone opportunities. If, by all means, such an overall cap has to be established, the CBOT has to carefully factor in all the differences between (FW vs., capstone) and within (across capstone options).



LOMA LINDA UNIVERSITY

School of Allied Health Professions

Dear Heather Martin, Jody Quesada and the CBOT members:

Thank you for the opportunity to participate in the public comment portion of the CBOT Administrative Committee Meeting on August 18, 2023 at 11:00 am agenda item numbers 4 – 8. In collaboration with fellow Doctorate Capstone Coordinators Dr. Susan MacDermott and Dr. Kathryn Wise I have summarized our thoughts below.

Agenda items 4 & 6:

The capstone experience regarding a site mentor is intended to be a mentorship rather than supervision in the traditional clinical practice direct patient care scenario familiar to us when we think of supervision in the context of fieldwork. The 2018 ACOTE Standard D.1.4 addresses supervision or mentoring in terms of the entire capstone committee and not specific to the site mentor. D.1.6 speaks to site mentoring. This is specific to the content expert and/or the site mentor. This is not supervision in the sense of patient care or billable services as we would typically associate with fieldwork experiences and the associated supervision. We respectfully request items 4 & 6 to be omitted.

2018 ACOTE Standards

D.1.4. MOUs for Doctoral Capstone Experience

Ensure that there is a valid memorandum of understanding for the doctoral capstone experience, that, at a minimum, includes individualized specific objectives, plans for supervision or mentoring, and responsibilities of all parties. The memorandum of understanding must be signed by both parties.

D.1.6. Mentor for Doctoral Capstone

Document and verify that the student is mentored by an individual with expertise consistent with the student's area of focus prior to the onset of the doctoral capstone experience. The mentor does not have to be an occupational therapist.

Agenda item 5:

Clarification may be helpful in terms of how CBOT defines the term "clinical". For example, development of treatment interventions for pelvic health can be considered as a clinical capstone. However, due to the nature of providing pelvic health the capstone student may not provide the actual treatment, rather it would be provided by their site mentor. This type of clinical capstone would not require supervision in the direct patient care concept often thought of in the context of fieldwork.

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Does "clinical" in the scope of CBOT's definition equate to direct patient care? If so then the direct patient care component is what may be supervised since the student is not a licensed OT, while the capstone project is mentored. Mentored in the sense of the overall project may also include feedback on the literature review, needs assessment, and other chapters of the capstone report.

Additional consideration in clarifying a clinical capstone and supervision are the capstone perspectives on site mentor.

Site mentor definition: content expert in the area of the student's focus.

Examples of a site mentor in a clinical setting:

Medical Setting-> nurse, physician, respiratory therapist, physical therapist, social worker

School Setting-> teacher, director of special education, school psychologist

Agenda item 7-8:

If CBOT is defining clinical as direct patient care, then something to consider, is that an OTA is not able to provide direct patient care clinical supervision to an EOTD student as noted in the ACOTE C.1.11 fieldwork standard as it is required for an OTR to provide supervision. However, an OTA could be a capstone mentor in areas such as administration, leadership, program development, education, policy development, theory development. We respectfully request items 7 & 8 to be omitted.

Thank you for the opportunity to contribute to the discussion of ensuring the consumer as a patient, client, and student protection as it transcends practice settings.

Sincerely,



Penny Stack, OTD, OTR/L, CLT
Doctoral Capstone Coordinator

A Seventh-day Adventist Organization

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STANDARD NUMBER	ACCREDITATION STANDARDS FOR A DOCTORAL-DEGREE-LEVEL EDUCATIONAL PROGRAM FOR THE OCCUPATIONAL THERAPIST	ACCREDITATION STANDARDS FOR A MASTER'S-DEGREE-LEVEL EDUCATIONAL PROGRAM FOR THE OCCUPATIONAL THERAPIST	ACCREDITATION STANDARDS FOR A BACCALAUREATE-DEGREE-LEVEL EDUCATIONAL PROGRAM FOR THE OCCUPATIONAL THERAPY ASSISTANT	ACCREDITATION STANDARDS FOR AN ASSOCIATE-DEGREE-LEVEL EDUCATIONAL PROGRAM FOR THE OCCUPATIONAL THERAPY ASSISTANT
C.1.15. Evaluation of Student Performance on Level II Fieldwork				
C.1.15.	Document mechanisms for requiring formal evaluation of student performance on Level II fieldwork (e.g., the AOTA <i>Fieldwork Performance Evaluation for the Occupational Therapy Student</i> or equivalent).	Document mechanisms for requiring formal evaluation of student performance on Level II fieldwork (e.g., the AOTA <i>Fieldwork Performance Evaluation for the Occupational Therapy Student</i> or equivalent).	Document mechanisms for requiring formal evaluation of student performance on Level II fieldwork (e.g., the AOTA <i>Fieldwork Performance Evaluation for the Occupational Therapy Assistant Student</i> or equivalent).	Document mechanisms for requiring formal evaluation of student performance on Level II fieldwork (e.g., the AOTA <i>Fieldwork Performance Evaluation for the Occupational Therapy Assistant Student</i> or equivalent).
C.1.16. Fieldwork Supervision Outside the U.S.				
C.1.16.	Document and verify that students attending Level II fieldwork outside the United States are supervised by an occupational therapist who graduated from a program approved by the World Federation of Occupational Therapists and has at least 1 year of experience in practice prior to the onset of Level II fieldwork.	Document and verify that students attending Level II fieldwork outside the United States are supervised by an occupational therapist who graduated from a program approved by the World Federation of Occupational Therapists and has at least 1 year of experience in practice prior to the onset of Level II fieldwork.	Document and verify that students attending Level II fieldwork outside the United States are supervised by an occupational therapist who graduated from a program approved by the World Federation of Occupational Therapists and has at least 1 year of experience in practice prior to the onset of Level II fieldwork.	Document and verify that students attending Level II fieldwork outside the United States are supervised by an occupational therapist who graduated from a program approved by the World Federation of Occupational Therapists and has at least 1 year of experience in practice prior to the onset of Level II fieldwork.
<p>D.1.0. DOCTORAL CAPSTONE</p> <p>The doctoral capstone shall be an integral part of the program's curriculum design. The goal of the doctoral capstone is to provide an in-depth exposure to one or more of the following: clinical practice skills, research skills, administration, leadership, program and policy development, advocacy, education, and theory development.</p> <p>The doctoral capstone consists of two parts:</p> <ul style="list-style-type: none"> • Capstone project • Capstone experience <p>The student will complete an individual capstone project to demonstrate synthesis and application of knowledge gained.</p> <p>The student will complete an individual 14-week capstone experience that must be started after completion of all coursework and Level II fieldwork, and completion of preparatory activities defined in D.1.3.</p> <p>The doctoral capstone coordinator will:</p>		<p>D.1.0. BACCALAUREATE PROJECT</p> <p>The goal of the baccalaureate project is to provide an in-depth experience in one or more of the following: clinical practice skills, administration, leadership, advocacy, and education.</p> <p>The individual or group project allows student(s) to demonstrate application of knowledge gained. The baccalaureate project shall be an integral part of the program's curriculum design.</p> <p>The program will:</p>		



May 17, 2023

California Board of Occupational Therapy
c/o Heather Martin, Executive Officer
1610 Arden Way, Suite 121
Sacramento, CA 95815

Dear California Board of Occupational Therapy,

The Occupational Therapy Association of California is formally requesting that the California Board of Occupational Therapy reconsider the use of limits on mentorship and supervision of capstone students on occupational therapists. The use of the term “capstone supervision” is quite different from clinical supervision and should not be used interchangeably to describe the role of the occupational therapy practitioner in California that takes on the role of a capstone mentor. In many Occupational Therapy Doctorate (OTD) programs, the terms supervisor and mentor can both be used to refer to the capstone mentor and do not need to be an occupational therapist.

The Accreditation Council for Occupational Therapy Education (ACOTE) 2018 standard D.1.0 defines the doctoral capstone as follows:

D.1.0. DOCTORAL CAPSTONE The doctoral capstone shall be an integral part of the program’s curriculum design. The goal of the doctoral capstone is to provide an in-depth exposure to one or more of the following: clinical practice skills, research skills, administration, leadership, program and policy development, advocacy, education, and theory development. The doctoral capstone consists of two parts: the capstone project and capstone experience. The student will complete an individual capstone project to demonstrate synthesis and application of knowledge gained. The student will complete an individual 14-week capstone experience that must be started after completion of all coursework and Level II fieldwork, and completion of preparatory activities defined in D.1.3.

ACOTE 2018 Standards D.1.2, D.1.3, D.1.4, and D.1.6 describe the plan and preparation of a mentored doctoral capstone learning experience – which includes an experience and project portion (DeLuliis & Bednarski, 2020). It is in no way to be used to describe the “clinical supervision” relationship that is present in a fieldwork setting. The individual that takes on the role of a capstone mentor may “supervise” the students, but this is solely to take responsibility of them on site as it relates to understanding the in-depth area the agreed upon capstone experience and project. As outlined by ACOTE (2022), the goal of the doctoral capstone is to provide an in-depth exposure and mentored learning in a designated area of interest. These in-depth areas include clinical practice skills, research skills, administration, leadership, program and policy development, advocacy, education, and theory development.

At this point, no other state boards have enacted any limits on occupational therapists in the supervision and mentorship of capstone students. **We are requesting that the board make an exception for the limits on occupational therapists to supervise a capstone student to only those projects focused in the “clinical practice skills” focus area and not the other identified capstone areas of research skills, administration, leadership, program and policy development, advocacy, education, and theory development.** Even with a project focused on “clinical practice skills” the doctoral capstone is not intended to be solely clinically based or provide treatment that is billable as occupational therapy services.

Thank you for your consideration.

The California Doctoral Capstone Coordinator Working Group

DeLuliis, E. D., & Bednarski, J. A. (2020). *The Entry-Level Occupational Therapy Doctorate Capstone A Framework for The Experience and Project*. Slack.

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Public comment regarding supervision of doctoral capstone students

(Received 3/20/2023)

To the Board of Occupational Therapy, for consideration regarding supervision parameters for doctoral capstone students:

Having spent a significant amount of time reflecting on this question, I believe what made that process difficult for me was the phrasing of the query. Rather than focusing on the supervisee role, I think the question is how many people can one OT supervise. Although the capstone student is not providing direct patient care, to provide them with the quality educational experience such an undertaking deserves, it will take time and attention from the supervising OT. If one argued there could be more capstone students since it's a non-clinical role, I feel that might be a misguided demand on the supervisor's ability to also attend to those providing patient care.

I'm not exactly sure where that ratio should be set, but I believe that one OT should not have to supervise more than four or five other people at any given time. There would also be the variables to consider, such as the size of their caseload and/or what other administrative duties are assigned to the OT. As for supervisee limits of four or five, the OT could be supervising:

- 2 OTA's, 1 OT student, and 1 capstone student (4)
- 1 OTA, 1 OT student, 1 limited permit OTA, and 2 capstone students (5)

Of course, there are a wide range of possibilities. One can see though, especially in the second scenario, that maybe five supervisees may not be a sustainable number. I feel it also shows the value of setting the limit on the supervisor and allows them and their supervisor to design the skill mix within the parameter.

Thank you for your time and consideration.

CALIFORNIA BOARD OF OCCUPATIONAL THERAPY REGULATIONS

Title 16, Division 39, California Code of Regulations

§ 4181. Supervision Parameters

(a) Appropriate supervision of an occupational therapy assistant includes, at a minimum:

(1) The weekly review of the occupational therapy plan and implementation and periodic onsite review by the supervising occupational therapist. The weekly review shall encompass all aspects of occupational therapy services and be completed by telecommunication or onsite.

(2) Documentation of the supervision, which shall include either documentation of direct client care by the supervising occupational therapist, documentation of review of the client's medical and/or treatment record and the occupational therapy services provided by the occupational therapy assistant, or co-signature of the occupational therapy assistant's documentation.

(3) The supervising occupational therapist shall be readily available in person or by telecommunication to the occupational therapy assistant at all times while the occupational therapy assistant is providing occupational therapy services.

(4) The supervising occupational therapist shall provide periodic on-site supervision and observation of client care rendered by the occupational therapy assistant.

(b) The supervising occupational therapist shall at all times be responsible for all occupational therapy services provided by an occupational therapy assistant, a limited permit holder, a student or an aide. The supervising occupational therapist has continuing responsibility to follow the progress of each client, provide direct care to the client, and assure that the occupational therapy assistant, limited permit holder, student or aide do not function autonomously.

(c) The level of supervision for all personnel is determined by the supervising occupational therapist whose responsibility it is to ensure that the amount, degree, and pattern of supervision are consistent with the knowledge, skill and ability of the person being supervised.

(d) Occupational therapy assistants may supervise:

(1) Level I occupational therapy students;

(2) Level I and Level II occupational therapy assistant students; and

(3) Aides providing non-client related tasks-;

(4) Doctoral capstone students completing an experience in research skills, administration, leadership, program and policy development, advocacy, or education, as required by and accredited educational program;

(5) No more than a total of three Level I fieldwork students, Level II fieldwork students, or Limited Permit holders at any one time; and

(6) No more than 20 Level I fieldwork students in a faculty-led fieldwork.

(e) Occupational therapists may supervise:

(1) Doctoral capstone students completing an experience in research skills, administration, leadership, program and policy development, advocacy, and education, as required by and accredited educational program;

(2) No more than a total of three Level I fieldwork students, Level II fieldwork students, Limited Permit holders, or Doctoral capstone students completing a clinical, direct patient care experience, at any one time; and

(3) No more than 20 Level I fieldwork students in a faculty-led fieldwork.

~~(e)~~ (f) The supervising occupational therapist shall determine that the occupational therapy practitioner possesses a current license or permit to practice occupational therapy prior to allowing the person to provide occupational therapy services.