

FAMILY FOCUS BOX

Helpful Hints for Maximizing Therapy

- All therapy should be related to the goals that you, your child, and therapist set at the evaluation.
- You know your child best! Tell your therapist what motivates your child at home and what might help if he or she is frustrated with a new challenge.
- Ask your therapists for activities to help carry over gains at home. Let your therapist know if there are challenges.
- Involve the whole family. Siblings or other family members can be a great motivator.
- As your child nears discharge, ask the therapist when you should return for a re-evaluation.

CASE STUDY

This case study is a continuation of the child presented in Chapter 6. The child is an 8-year-old boy with right hemiplegia due to AIS of the left middle cerebral artery sustained during the perinatal period, who is referred to outpatient physical and occupational therapy 2 weeks after receiving botulinum toxin injections to his right upper and lower extremity (right brachioradialis, biceps brachii, gastrocnemius, hamstrings). His stated goals for occupational therapy include increased ability to use his right upper extremity to manage the zip on his coat and his shoelaces, and his goal for physical therapy is to “walk faster without a limp.” Both the occupational and physical therapists collaborated while setting goals and a plan of care in order to carry over and reinforce learning.

Occupational Therapy

The occupational therapist observed the child’s function in the 2 bimanual activities he identified as most problematic for him. The boy reported these tasks were particularly difficult when at school when there is pressure on time, and he was aware of being slower than his friends. Through task observation Goal Attainment Scaling (GAS) goals were devised and the tasks video-recorded. Challenging components of functional performance observed included maintaining balance in standing while using 2 hands cooperatively, accurate grasp and release of the edge of the coat or lace, lack of experience of the steps in the process, difficulty actively extending his right wrist and abducting his right thumb to achieve the appropriate grasp, and increased tone of right arm when under time pressure or stressed (associated reactions). Through discussion with the boy and his family, it was agreed to practice at home initially when there was more time. It was agreed that each day both tasks would be performed when appropriate in the usual daily routine and time arranged for focused task practice. A thumb abduction splint that supported the wrist position to neutral and opened the thumb web space was provided. Practice of shoelace tying was prescribed using the shoe on the boy’s lap to maximize visual regard and minimize balance demands. A backward chaining approach with the boy performing the final stage of each task was utilized. With confidence and ability to perform the final step, the preceding step of the task was taught using both verbal and demonstration cues. Eventual transition to undertaking the tasks in seated or supported standing (eg, leaning with back to the wall) was found easier by the boy so he could attend to his hands. After 6 weeks of daily practice GAS goals were reviewed and videoed and the boy encouraged to reflect on what changes he found and what strategies worked best for him that he might find helpful for other tasks.

Physical Therapy

In physical therapy, the therapist developed goals with the child and family focused on walking at a fast speed and running. She recommended physical therapy 3 times/week for 8 weeks, with a plan of care that emphasized regaining lost range of motion, strengthening key muscle groups in the right leg, improving active control throughout the gait cycle, and gait training. By using the literature and concepts discussed previously in this chapter, the clinician selected the intervention strategies of strengthening using progressive resistive exercise and neuromuscular re-education, using functional electric stimulation, treadmill training, and overground gait training as well as task-specific practice for running. Although these largely focus on the philosophy of recovery, the clinician also utilized some compensatory strategies by prescribing a new AFO to aid in foot lift during the swing phase and to help maintain optimal postural alignment. In addition, the physical therapist discussed the child’s goals with the occupational therapist and integrated increased opportunities for right upper extremity practice into physical therapy sessions. After the completion of the physical therapy course of care, the child and his mother both rated a high level of satisfaction with his goal attainment.