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Increasing Quality of Life and Occupational Performance: A Treatment Protocol for Military Burn Patients and Their Families

by

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A Scholarly Project

Submitted to the Occupational Therapy Department of the

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in partial fulfillment of the requirements

for the degree of

Master's of Occupational Therapy

Grand Forks, North Dakota

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This scholarly project, submitted by Emma Chafin, MOTS and Jessica Lambert, MOTS in partial fulfillment of the requirement for the Degree of Master of Occupational Therapy from the University of North Dakota, has been read by the Faculty Advisor under whom the work has been done and is hereby approved.

Nicole Harris

Faculty Advisor

4/9/21

Date

PERMISSION

Title: Increasing Quality of Life and Occupational Performance: A Treatment Protocol for Military Burn Patients and Their Families

Department: Occupational Therapy

Degree: Master of Occupational Therapy

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TABLE OF CONTENTS

ACKNOWLEDGEMENTS……………………………………………………………v

ABSTRACT…………………………………………………………………...vi

CHAPTER

I. INTRODUCTION………………………………………………………………1

II. LITERATURE REVIEW………………………………………………………3

III. METHODOLOGY……………………………………………………………...32

IV. PRODUCT…………………………………………………………………...35

V. SUMMARY………………………………………………………………..81

APPENDIX……………………………………………………………………84

REFERENCES………………………………………………………………104

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ABSTRACT

Title: Increasing Quality of Life and Occupational Performance: A Treatment Protocol for Military Burn Patients and Their Families

Background: The current scholarly project came about by a common interest in the veteran population by both students, Emma Chafin and Jessica Lambert. The interest in burns was sparked after studying a unit on burn injuries in a graduate occupational therapy class, which then led to initial research identifying a need for an occupational therapy protocol for veterans who have experienced burns. After identifying this as a current need, the researchers landed on the topic of developing an occupational therapy protocol for improving quality of life and increasing occupational performance in veterans who have experienced a traumatic burn injury.

Upon identifying an appropriate model to help guide the development of the protocol, it was important to consider the population of military service members who have acquired a burn injury and all the unique challenges relevant to their recovery. Due to these factors, it was decided that the use of a multi-dimensional model would be necessary to help guide treatment. The Canadian Model of Occupational Performance and Engagement (CMOP-E) would be the most beneficial fit for the intended population as it considers not only physical factors related to rehabilitative outcomes, but also accounts for all other factors, psychological, social, and spiritual, that can impact recovery. In order to guide occupational therapy in practice, the CMOP-E is often used in conjunction with two related models, the Canadian Model of Client-Centered Enablement and the Canadian Process Practice Framework. Together, these three models make up

what is considered the Triple Model Framework. This framework was constructed with the assumption that health and well-being are supported through participation in occupations that are meaningful to the person (Krupa, 2016). This assumption is directly in alignment with the purpose as well as the desired outcomes of the designed protocol. The framework also highlights ideas and practice approaches that increase the understanding of the psychological, emotional, and social factors related to human occupation (Turpin & Iwama, 2011).

Today, fewer opportunities exist for occupational therapists to be involved in providing rehabilitative services to military service members, although it could be argued that those services are needed now more than ever (Cogan, 2014). Military service members are returning home with both prominent and delayed combat-related injuries and symptoms (Cogan, 2014). If left untreated, there could be long-term effects that threaten to disrupt facets of military member's personal and professional lives as well as their physical and mental well-being. Occupational therapy services can assist in the outpatient rehabilitation and community reintegration aspects that apply best to this population and their unique challenges.

Purpose: The purpose of this scholarly project was to develop a treatment protocol to address the challenges that can affect quality of life and occupational performance of military burn patients and their families. Occupational therapy can offer skilled treatment to help facilitate a successful transition back into civilian life after sustaining a life-altering combat wound.

Methods: The creators of the protocol reviewed current literature regarding adverse consequences of military burns, related comorbidities, existing programs and services for military burn survivors, and occupational therapy's role in military burn treatment. From the results of the literature review, five sessions for individualized intervention and four sessions for family intervention were created to address the unique needs of the intended population.

Conclusion: The treatment protocol, *Increasing Quality of Life and Occupational Performance: A Treatment Protocol for Military Burn Patients and Their Families,* was designed to be utilized as a tool by occupational therapy practitioners or future occupational therapy students during the community reintegration phase of the rehabilitation process for military veterans ages 18-65 who have incurred burn wounds from combat, as well as their families.

Chapter I: Introduction

In 2018, there were an estimated 18.0 million veterans of the U.S. armed forces. This is about 7% of the current adult population within the United States. Of those service members, post-9/11 veterans had a 39% chance of having a disability rating of 70% or more (United States Census Bureau, 2020). According to the United States of Veterans Affairs (2020), VA disability ratings are determined based on the level of functional impairment that veterans experience due to service-related injuries. Functional impairments of past and present active service members can vary from serious long-term consequences such as burns, amputations, spinal cord injuries, or traumatic brain injuries (TBIs) to a range of other chronic physical and psychosocial ailments.

One specific functional impairment seen within the veteran population that requires extensive rehabilitation are combat-related burns. These traumatic injuries can be life-altering by decreasing performance in meaningful daily occupations such as activities of daily living, instrumental activities of daily living, social participation, and work. The decrease in occupational performance and engagement can affect the veteran's overall quality of life (Mata et al., 2017). This population and their families may benefit from skilled occupational therapy services to help facilitate a successful transition back into the community as well as increase overall quality of life and occupational performance after sustaining a life-altering combat wound.

Currently, there are limited protocols for military burn patients that specifically look at meaningful occupations with family involvement. Reintegrating back into civilian life is not an easy transition as they resume their pre-military roles and routines. The proposed product is an occupation-based treatment protocol that encompasses aspects of the community reintegration phase that have been identified as crucial to increasing occupational performance and engagement within military burn patients. Occupational therapists can use this protocol to work with military burn patients when they are leaving the acute phase and entering into the community reintegration phase of their recovery. The following protocol is guided by the Canadian Model of Occupational Performance and Engagement (CMOP-E) which focuses on not only the physical aspects of recovery, but also the psychological, social, and spiritual aspects as well. This model looks at the individual's engagement in their daily occupations and routines and helps to guide the therapy protocol to be evidence-based and client-centered to achieve the best outcomes. *The Occupational Therapy Practice Framework (OTPF-4)* has also been used throughout the protocol to utilize occupational therapy language and allow for application of the occupational therapy process.

The following chapters include a thorough review of literature supporting the need for additional occupation-based treatment protocols for military burn patients and their families, a detailed description of the methodology used to create the protocol, the protocol, and additional handouts in the appendices.

Chapter II: Literature Review

Adverse Consequences of Military Burns

Burns are a common injury that can vary in shape, size, cause, and severity. In the present day, most of the outcomes related to acute burn rehabilitation are low in mortality when considering the large number of burns sustained yearly (Waters et al., 2015). With an increase in survival means there is also an increase in morbidities related to the acquired burn injury. According to the World Health Organization (WHO), "Burns are a global public health problem, accounting for an estimated 180,000 deaths annually" (2018). In 2008, the United States estimated 410,000 reported burns with about 40,000 causing hospitalization (WHO, 2018). While anyone can experience a burn, populations such as active military members have a greater chance of acquiring a burn injury. Burn injuries in active and inactive military members come with their own unique challenges, including a variety of comorbidities that were most likely created by environmental factors such as active combat situations. According to the Department of Defense's Congressionally Directed Medical Research Programs (CDMRP), military burn injuries are often times more severe and more devastating than civilian burns due to the ways in which the injuries are acquired (2015). Most military burns are caused from the detonation of explosive devices, which often lead to greater injury, larger full thickness burn size, adverse effects such as scarring and other related comorbidities

(Congressionally Directed Medical Research Programs [CDMRP], 2015). Given the increased severity of burns experienced by those serving in the military, it is necessary to consider the complications and treatment approaches in order to ensure those serving our country are being treated appropriately. While occupational therapy is commonly recognized as a profession providing treatment in initial burn recovery, there are areas of treatment where a case could be made that occupational therapy services are underutilized during the community reintegration phase for returning service members and their families.

Scarring and Deformity

Scarring and deformity are common adverse consequences of experiencing a deep or extended burn (Spronk et al., 2019). Due to the nature of most severe military burns, scarring will be present and could cause physical and psychological difficulties for the patient (Spronk et al., 2019). Skin grafts may also be necessary in many cases of traumatic burn injuries. Scarring can also occur in the areas of the body where the grafts were taken from, therefore causing more scarring than just the initial burn areas (Spronk et al., 2019). Certain client-factors can relate to the reduced quality of scars including darker skin types, full-thickness burns, increased number of operations, higher percentages of burn surface area, and slowed wound healing (Spronk et al., 2019). The maturation of scars can take up to several years depending on the severity of the burn. Therefore, it is important to continue to treat the scar tissue for long term to prevent contracture and increase the elasticity and flexibility of the skin (Spronk et al., 2019). Each patient is different in how they will scar and how they will perceive their scars. The

psychosocial factors that come along with having scars to cause deformity or creating differences on one's body can be overwhelming at times and therefore need to be addressed (Spronk et al., 2019). As scar tissue is healing or even after it is fully matured, it can present with pain, tightness, or what is called postburn itch (Spronk et al., 2019).

Postburn Itch

Postburn itch is an uncomfortable sensation that occurs during healing of the skin and scar tissue following a severe burn. Nedelec and LaSalle (2018), identified that people can feel a burn for up to 30 years after their injury. Postburn itch can stand in the way of a client's occupational participation and performance level because of the continued focus on the need or desire to itch along with the continued feelings of being uncomfortable. Performance in certain occupations, specifically with fine motor skills or occupations such as ADLs, IADLs, sleep, and leisure activities are often the areas most affected because of the physical and mental impacts (Nedelec & LaSalle, 2018). It is important to note that following a burn, it is typical for one to have to indefinitely use a topical cream to moisturize the burn area for scar management. Some of these ointments cause a cooling sensation, which may in fact increase the itch (Nedelec & LaSalle, 2018). Other treatments such as pressure garments, massage therapy, topical solutions, oral antihistamines, diets, Botox, gabapentin, silicone or gel sheets, transcutaneous electrical nerve stimulation (TENS), and psychological treatments have been used to decrease this postburn itch (Nedelec & LaSalle, 2018). However, each person is different and reacts differently to varying treatments, because there is not a one size fits all cure or treatment approach for the postburn itching effect (Nedelec & LaSalle, 2018).

Pain

Since burns are one of the most painful types of trauma a person can experience, there is a lot of pain management and anxiety management that goes along with the treatment and rehabilitation of burns (Khanolkar, Metgud, & Verma, 2013). A study by Khanolkar et al. (2013) discussed the amount of pain that burn patients withstand and the importance of therapies in the rehabilitation of a traumatic burn to keep the patient from experiencing severe long-term disability. Patients tend to lack range of motion in the joints that have experienced burns. As interventions in therapy, these patients work on range of motion that creates more pain known as, "procedural pain" (Khanolkar et al., 2013). After many times of experiencing this procedural pain, the client can build up anxiety in anticipation of the pain to come during therapeutic activities (Khanolkar et al., 2013). In addition to addressing burn-related symptoms, it is important to recognize that military burns are usually accompanied by various comorbidities that may need to be addressed in treatment. Sometimes the symptoms of these comorbidities present separately and other times it is hard to distinguish between them. Some of the most common comorbidities seen in this population can include inhalation injuries, brain injuries, and psychosocial related challenges (CDMRP, 2015).

Related Comorbidities of Military Burns

Inhalation Injuries

During the last few wars in United States history, particularly the Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) deployments, lung damage is a commonly seen comorbidity (Waters et al., 2015). Lung damage can be attributed to

military tactics including the use of smoke bombs which produce large amounts of particles and toxic gases. Military burn patients are also identified as sufferers of inhalation injuries such as acute respiratory distress syndrome (ARDS) due to smoke or chemical inhalation. ARDS affects approximately 40-54% of burn patients and can be associated with high rates of mortality (Waters et al., 2015). When comparing military burn patients to civilian burn patients, the military group in general had more severe burn injuries and a higher prevalence of inhalation injury, although the prevalence of ARDS was about equal for both groups (Waters et al., 2015). This survival rate could also be due to the evolving changes of military burn care and evacuation strategies that were developed with the most recent operations in Iraq and Afghanistan.

Mild Traumatic Brain Injuries

Combat injuries associated with this population, particularly those involved in OEF/OIF, include injuries from explosive devices causing significant physical and cognitive impairments including mild traumatic brain injuries (mTBI). When compared to civilian population-based statistics, the prevalence of mTBI in OEF/OIF patients who were exposed to explosive devices was at a high of 59% (Cooper et al., 2010). The cognitive effects specific to this type of injury can include distractibility, attention deficit, poor working memory, and decreased mental processing (Cooper et al., 2010). These deficits are dependent upon the severity of injury as well as the phase of recovery in which the individual is in. Cooper et al. (2010) additionally discovered that in military burn patients, the presence of mTBI was associated with slightly lower cognitive performance in areas of attention and speed of processing. It is important to further

recognize that due to the unique nature surrounding the acquisition of these injuries, there are often other influencing factors like post-traumatic stress disorder (PTSD) that can have an impact on cognitive functioning as well. One of the primary challenges in determining the specific occurrence of mTBI and PTSD in military service members in OEF/OIF is that each condition shares a variety of overlapping symptoms which can be very nonspecific (Gaylord et al., 2008). This is important to note when evaluating military burn patients to determine the appropriate course for treatment and whether the comorbidities are in fact separate or co-occurring.

Psychosocial Factors

Due to the complicated nature of injuries that military burn patients endure, it is important to approach their care from a holistic perspective and ensure that physical, cognitive, and psychosocial aspects of rehabilitation are addressed in treatment. There continues to be limited research addressing the long-term functional and psychosocial adaptation of burn survivors as most military burn protocols tend to focus on the physical aspects of rehabilitation (Yoder, McFall, & Glasser, 2017). This is most likely because returning military members are facing the repercussions of polytrauma and they acquire more acute attention. Since polytrauma injuries are complex in nature, it is important to recognize that they can often present with delayed or sometimes inaccurate associated symptoms due to overlap with other related challenges (Besemann et al., 2018). Unfortunately, as more military veterans are returning to the United States, the research is showing that many of them are not receiving the care they may need in regard to the psychosocial contexts of their lives (Besemann et al., 2018). Two psychosocial areas

commonly cited in literature that military burn victims may experience, either as a direct result of the injury or through participation in active duty, are post-traumatic stress disorder and a loss or change in one's identity.

Post-Traumatic Stress Disorder

Combat related post-traumatic stress disorder (PTSD) is unfortunately a common side-effect for active military personnel. Symptoms can be delayed or misinterpreted for other diagnoses, but can include recurring nightmares, flashbacks, memory loss, insomnia, depression, avoidance of social interaction, fear, decreased energy, drug and alcohol use, and the inability to concentrate (Robinette, Woods, & Gerardi, 2009). If left untreated, these symptoms can negatively affect an individual's person and professional life. Combat related PTSD may cause veterans to socially isolate, ineffectively negotiate their life roles, and disrupt their professional abilities (Robinette et al., 2009).

Although PTSD is often attributed to combat related activities in deployment, it should also be considered to be a direct result of the burn injury itself. Severe burns often produce psychological problems due to the traumatic occurrence of the injury, the pain associated with the injury, and body deformity that may also occur (Mora et al., 2009). One study reported that one fifth of US soldiers returning from OIF/OEF deployments meet criteria for PTSD diagnosis. "The incidence of PTSD has been reported between 27% to 46% in burn-wounded combat casualties and between 8% to 45% in civilians with burns" (Mora et al., 2009, p S183). In this instance, PTSD is prevalent in relation to these types of injuries, particularly those who have been injured by an improvised explosive device (IED) and have burns in addition to a mild traumatic brain injury (Mora

et al., 2009). By addressing PTSD symptoms appropriately, it can potentially help decrease related barriers for military burn survivors and hopefully lead to an increase in occupational performance.

Change in Identity

Another important factor to consider in the therapy process with military burn victims is that many of them are losing an established identity that was built up within their time spent immersed within military culture (Besemann et al., 2018). As part of the culture, military members often give great respect to those who are physically fit and have engaged in active deployment. In addition, many of them view themselves within the role of a "protector" who is specifically trained to handle extreme situations in crisis (Besemann et al., 2018). Most of these individuals also spend a large amount of time in excellent physical condition to account for the extreme conditions they must face. Because of a strong tie in shared roles and exclusivity, the military population has been perceived to experience a disconnect from civilian society that increases when they return and have to reintegrate into society. This disconnect can lead to a negative perception of self and others and can lead to an increase in psychological distress and decrease in overall well-being (Besemann et al., 2018).

Anytime a physical or mental health issue is experienced, it can feel like a betrayal of trust in a person's capabilities (Besemann et al., 2018). Military burn survivors may feel this type of loss of identity due to their sustained injuries. When adding the potential loss of career on top of physical and mental challenges, it can really have an extreme impact on an individual. It often requires the individual to redefine

relationships between themselves, their environments, and those closest to them (Besemann et al., 2018). Accounting for the identity challenges specific to this population is important when addressing rehabilitation factors.

Review of Existing Programs and Services

Immediate Care and Evacuation

Military burns can be traumatic and present with a wide variety of issues and comorbidities that affect the treatment of the client and their injuries from start to finish. When a major burn occurs in combat, there are a series of steps to the care of the individual that are followed in order to decrease mortality and related morbidities. Initial wound care after injury takes place in combat support hospitals (CSH). These hospitals are intended to provide short-term care for the stabilization of people injured in combat before they are rapidly evacuated from the combat zone to a more stable hospital (Stout et al., 2007). "The mission of the CSH is to provide resuscitation, initial wound surgery, postoperative therapy, and return to duty those soldiers in the combat zone who fall within the corps evacuation policy, or to stabilize patients for further evacuation" (Stout et al., 2007, p. 1148). When fully deployed, most CSH's consist of eight operating room tables and up to 296 inpatient beds (Stout et al., 2007). Although these CSH's can treat a wide variety of injuries, they are not designed for definitive care of patients with major burns (Stout et al., 2007). The amount of time that a patient may remain in the combat zone once wounded depends on the evacuation policy, which is determined by the situation on the ground for that combat zone (Stout et al., 2007). For example, in 2003 in Iraq, the patients were required to be air evacuated within 72 hours of their injury to

reach the safety of another hospital, specifically the Landstuhl Regional Medical Center in Germany (Stout et al., 2007). After the patients had been stabilized and deemed safe for a longer transfer, the patients were then sent to the U.S. Army Burn Center in Texas for further acute and rehabilitative care where they may receive a variety of services including wound care, occupational therapy, physical therapy, psychosocial care and patient education (United States Army Institute of Surgical Research [USAISR], 2018). From this burn center, the patients are then sent to acute long-term care, back to duty, or to civilian life depending on their needs.

Acute Care and Rehabilitation

In the acute care phase, military patients with traumatic burns are oftentimes admitted into the inpatient burn unit at the United States Army Institute for Surgical Research (USAISR) in San Antonio, Texas. This is where the client will receive immediate and continuous medical care such as surgery, wound care, treatment for infections and comorbidities (United States Army Institute for Surgical Research [USAISR], 2018). In this phase of recovery, the patient will have a multidisciplinary team that often treats following a medical model approach (USAISR, 2018). This acute team may consist of surgeons, physician assistants, nurses, and technicians with specialties in severe burn care (USAISR, 2018). Once the patient is stable, they will start working with the rehabilitation team, consisting of physical therapists, occupational therapists, and assistants (USAISR, 2018). The rehabilitation team utilizes an individualized plan for each patient which may entail prevention and correction of burn scar contracture and deformity, improving mobility, pain management, and functional

independence in activities of daily living (ADLs). After discharge from the hospital, the patient will then be sent to rehabilitative services through the burn clinic at the USAISR where they will receive outpatient services for physical therapy and occupational therapy. The goals for this outpatient setting generally focus on ADLs, Instrumental Activities of Daily Living (IADLs), leisure activities, and return to work (USAISR, 2018). Therapy sessions may also include joint mobility, scar tissue management, contracture management, prosthetic fitting and training, adaptive equipment training, patient and family education, and psychosocial adjustment (USAISR, 2018). A continuum of care for patients after discharge is available at this location; however, there are limited resources for military burn patients transitioning into their own communities away from the USAISR (USAISR, 2018).

Community Support Programs

As military burn patients transition back into the community, they may have access to resources such as Veterans Affairs (VA) and other services such as the Wounded Warrior Project (WWP) depending on their location. The VA has four separate missions in their service for veterans. These missions include: veterans' health care, veterans' benefits, national cemeteries, and the nation's preparedness to respond to war, natural disasters, terrorism, and national emergencies (United States Department of Veterans Affairs, 2020). The veterans who have been injured in combat due to burns have the VA as a resource for further health care throughout the continuum of their care. Another resource that may be available to veterans who have experienced traumatic burn injuries is the WWP. The WWP is a program that helps veterans, their families, and

caregivers with a variety of educational, health, and community support services. Some of the main topics include mental wellness, physical wellness, getting connected in their community, career and VA benefits counseling, and independence programs. This project provides a level of support to the veterans involved by finding them resources in their own communities and giving them support through peers, families, and professionals. Occupational therapy involvement is limited once discharge from rehab has occurred for these individuals. Programs such as the VA and WWP provide a certain level of support for military burn survivors; however, they do not provide a specific protocol for occupational therapists to use in the community reintegration phase of recovery specific to this population.

Although the overall mortality rate from burns has declined due to advances in acute burn management, there continues to be limited research on addressing the long-term effects of burn injuries on burn survivors (Yoder et al., 2017). Due to the higher survival rate of burn patients among military personnel, there is an increased need for occupational therapy services and other rehabilitative services (Waters et al., 2015). Occupational therapy can prepare a veteran who has experienced a severe burn for a successful transition into civilian life by returning to meaningful occupations through increased independence and improving quality of life (Mata et al., 2017). However, there is still a lack of research on the levels of activity and occupational performance of patients with severe burns after discharge and how they resume their professional roles in the community reintegration phase of their recovery (Ghrobani et al., 2017).

OT Role in Military Burn Treatment

Occupational therapy had a strong presence in helping to rehabilitate injured military service members in World War I and World War II (Cogan, 2014). Slowly over time, occupational therapy adapted to fulfill the varying needs throughout the decades and through those changes the military population became less of a primary focus (Cogan, 2014). Today, fewer opportunities exist for occupational therapists to be involved in providing rehabilitative services to military service members, although it could be argued that those services are needed now more than ever. "Both OEF and OIF are the longest wars in U.S. history and involve the most intense ground engagements in the period since the Vietnam War" (Cogan, 2014, p. 478). Military service members are returning home with both prominent and delayed combat-related injuries and symptoms. If left untreated, there could be long-term effects that threaten to disrupt facets of military member's personal and professional lives as well as their physical and mental well-being. It is important to explore and address the various ways in which occupational therapy services can assist in the outpatient rehabilitation and community reintegration aspects that apply best to this population and their unique challenges. Within the field of occupational therapy, the *Occupational Therapy Practice Framework: Domain and Process 4th Edition (OTPF-4)* is a framework that is used to help guide practice in clinical settings and is meant to be used concurrently with occupation-based theories, supporting evidence, and professional reasoning. The entire document was created with the initial idea that engaging in meaningful occupation leads to the promotion of health, well-being, and a better quality of life.

Community Reintegration

Returning from active duty and transitioning back into the community may be one of the most difficult transitions for a returning veteran. Occupational performance difficulties were identified in areas of relationships, school, physical health, sleep, and driving for service members returning from combat (Plach & Sells, 2013). When considering community reintegration for veterans returning to civilian life, it is important to be client-centered as well as to consider the environmental contexts of the individual. In a survey conducted by Yohannan, et al. (2012), it was found that most respondents felt that physical and occupational therapy interventions had a positive effect on their reintegration back into the community, particularly in areas related to returning to functioning roles within the family dynamic, returning to work, and socializing with others. This information is important to understand as gaining a client's "buy-in" into their therapy services is a large proponent of whether they are successful in reaching their intervention goals.

An occupational therapist would want to determine what meaningful occupations have been affected by the burn injury and what occupations the individual is willing or wanting to learn in order to keep them involved and improve their quality of life. A recent, qualitative study by Mata et al. (2017), used semi-structured interviews to identify meaningful occupations that have been affected after a burn injury to the upper extremities and how the burn affected the individual's identity in society. The researchers investigated the barriers to returning to meaningful occupations and participation in new, meaningful occupations after their burn injury (Mata et al., 2017). According to the

results of this study, the researchers found that people who experience burns to their hands and upper extremities suffer from a loss of occupational performance and quality of life, therefore, they need new, meaningful occupations or improvement in their condition to return back to old, meaningful occupations (Mata et. al., 2017). This study demonstrates that the most frequently reported interruptions of occupational performance were IADLs and the roles and habits of the client (Mata et. al., 2017). When discussing the affects their burn injuries have had on their occupational participation, roles, and self-identity, the participants of this study noted that they frequently had negative feelings of their current quality of life such as depression, anger, fear, and worry (Mata et. al., 2017). The physical, mental, and emotional barriers that inhibit a burn patient from returning to their meaningful occupations are factors that need to be addressed in order to overcome these barriers and improve their overall quality of life.

Quality of Life

Quality of life is often a subjective concept that varies by definition and can truly only be identified by the individual themself based on their values, beliefs, and other contextual factors. From an occupational therapy perspective, quality of life is often regarded as a direct outcome as well as the intended focus of occupation-based approaches to intervention. Quality of life is the dynamic evaluation of a person's life satisfaction including their perceptions of progress towards personal goals, the belief that they can continue to move towards those goals, a synthesis of current beliefs and feelings about oneself, their overall health and functioning, and any socioeconomic factors that may influence their lives (4th ed.; AOTA, 2020). In a study designed by Yoder, McFall,

and Glaser (2017), biological, psychological, social and spiritual perspectives are all included in helping to define the concept of quality of life in burn victims. These concepts align with the client factors and performance skills that can support or hinder occupational performance of these individuals. The study findings also suggested that burn recovery should involve a more biopsychosocial model of recovery as well as an increase in rehabilitation recovery (Yoder, et al., 2017).

According to Mata et al. (2017), the greater the surface area of burn, the more it will negatively impact a patient's quality of life. In a study that compared burned military personnel and civilians by Waters et al. (2015), it was found that the military personnel in general have greater burn surface area than civilians. Therefore, there is an established need for improvement of quality of life through returning to meaningful occupations through the use of occupational therapy (Mata et al., 2017). Mata et al. (2017) stated that every burn has a story and also discusses the importance for occupational therapy practitioners to remember this as it encompasses the traumatic experience that each individual may have experienced as well as their own individual journey to recovery. Occupational therapists have been trained in their educational foundation to use their therapeutic use of self to attend to each individual patient's needs and make their plan of care client-centered and meaningful (Mata et al., 2017). As the concept of quality of life can encompass a range of meaning for any given individual, it is important to consider multiple factors to address in treatment, including the topic of spirituality.

Spirituality

For most active and retired military members, spiritual care up until this point has been provided as an option for emotional support in the form of military chaplains (Smith-MacDonald, Morris, Raffin-Bouchal, & Sinclair, 2017). For this population, spirituality could also be addressed by an occupational therapist if it was deemed appropriate to include in aspects of treatment. In the realm of occupational therapy services, spirituality can be regarded as a client factor that can impact a person's level of motivation to engage in occupations in addition to providing meaning to their lives (American Occupational Therapy Association [AOTA], 2020). Billock (2005) defines spirituality as "a deep experience of meaning brought about by engaging in occupations that involve the enacting of personal values and beliefs, reflection, and intention within a supportive contextual environment" (p. 887). In this case, spirituality is not necessarily meant to be an extension of religion but can also include a range of meaning that can only be determined by the client. In an article by Smith-MacDonald et al. (2017), spirituality was found to have a positive impact on increasing the mental well-being of combat veterans. As increasing well-being and quality of life are the focus of most outcomes of occupational therapy services, it stands to reason that spirituality be included in the role of the occupational therapist when addressing the needs of military burn patients and their families.

Family Roles

Some assistance programs addressing community reintegration are in place for the returning veteran, however, limited information was found related to addressing changes

to family roles, routines, and expectations. Deployment and returning from active duty both carry a heavy amount of change that affects the entire family. It was found that 38% of active-duty service members are married with children, and more than 5% are single parents (Cogan, 2014). In addition, 34% of selective reserve members are married with children, and 9% are single parents (Cogan, 2014). These statistics indicate that many more services members have families than in past wars. At this point in time, it is unknown as to the extent of the long-term effects that multiple deployments have on families, especially those with younger children (Cogan, 2014). Although some measures have been taken to include family members in the support process for returning military members, a gap still exists in addressing the changes that occur within the family dynamic (Cogan, 2014).

In addition to addressing changes in family roles and routines, it is also important to address the impact that combat related injuries can have on the entire family unit. Among families with a disabled parent, child functioning is negatively correlated with compromised parenting, poor family functioning, and preexisting mental health conditions (Cozza et al., 2010). Based on these findings, children of combat-injured parents are likely to be at risk for increased distress and behavior problems (Cozza et al., 2010). Due to the negative correlation of child functioning with poor parental function, it is important to consider how occupational performance will be affected with this group of individuals. Occupational therapy can make an impact within this area of disruption for military burn patients and their families. In order to improve occupational function and performance, various strategies may need to be tried in order to address the impacts that

combat related injuries, such as burns, can have on the patient and their families. Prevention strategies may be important to employ postinjury to help children and families deal with distress and disruption to their daily lives. This includes helping military burn patients and their families tailor daily activities and routines to address the unique challenges they face and optimize health and wellness for all (Cozza et al., 2014).

Impacted Occupations

Driving

Understanding the client as well as their past and current experiences are also important factors to consider when facilitating reintegration back into civilian life. One study found that during the first five years after returning from deployment, OIF/OEF veterans have a 75% greater risk of death from a motor vehicle accident than the general population (Lew et al., 2011). One of the hypotheses behind these findings is that being exposed and surviving through traumatic experiences, such as active combat, may lead to a sense of invulnerability and result in an increase in risk-taking behavior (Lew et al., 2011). Another explanation to consider is that veterans involved in the OIF/OEF may experience temporary or significant cognitive dysfunctions that may occur because of PTSD or mTBI symptoms (Lew et al., 2011). This cognitive dysfunction can have a negative impact on cognitive and physical skills that are necessary to perform occupations such as driving within the community and lead to a higher risk for motor vehicle accidents.

Understanding the client's cultural and environmental contexts are also important factors to consider during the community reintegration phase of rehabilitation. When in

active duty on tour, many veterans received training on how to drive in combat related contexts (Lew et al., 2011). When they return to civilian life, it may be difficult to switch environments and employ different performance skills necessary for civilian driving (Lew et al., 2011). Community mobility, specifically driving in this case, is important to maintain independence and self-sufficiency for many people. It gets them out and involved in the community, serves as a way to gather necessary resources, as well as serves as a way to get to work in order to provide for oneself and their families.

Work

Returning to the civilian workforce can be particularly challenging for military veterans. Chronic health conditions paired with comorbidities, such as PTSD, significantly increase the odds of early retirement or job loss before age 60 years (Davis et al., 2018). A 2015 analysis found that veterans' participation in the workforce declined over the previous 35 years in close correlation with growth in service-connected disability (Davis et al., 2018). In a survey conducted by Prudential (2012), a higher percentage rate of veteran unemployment at 30% compared to 16% for civilians in the same age range was found. The survey also found that 98% of survey participants reported one to three service-related challenges to reentering the workforce (Prudential, 2012). Since it can be such a difficult transition for some, many veterans have found success in utilizing transitional work programs or supported employment opportunities through vocational rehabilitation (Davis et al., 2018). In a study by Davis et al. (2018), they found that individual placement and supported (IPS) employment programs were more successful than the transitional work programs at helping veterans with PTSD

acquire and continue gainful employment. The deficits in the outcomes of a transitional work program could be attributed to several factors. One factor could be that transitional work programs usually use prearranged assignments with contracted employers, whereas IPS employment programs try to match a veterans' preferences, skills and abilities with available job opportunities (Davis et al., 2018). Another factor to consider is that IPS employment programs typically work in collaboration with the mental health treatment team of the veteran (Davis et al., 2018). This is important to note as interdisciplinary involvement may make all the difference in ensuring the veteran is successful in reintegrating back into the workforce.

Social Participation

Another one of the main human occupations according to the *OTPF-4* is social participation which has been demonstrated to be an area of concern for military veterans and injured military veterans in their transition back to civilian life in their own communities (Sayer et al., 2010). A study done by Sayer et al. (2010) found that 40% of veterans surveyed reported having difficulties re-establishing old friendships and making new friends. Another 28% of veterans reported having difficulty maintaining military friendships once they have re-entered civilian life (Sayer et al., 2010). Additionally, 49% of the sample stated that they have difficulty participating in community activities due to feeling distant or feeling like they do not belong (Sayer et al., 2010). Veterans who have experienced traumatic burns may also feel distant and isolated from their community which could impede recovery from psychological and physical ailments (Gorman, Scoglio, Smolinsky, Russo, & Drebing, 2018). This outcome demonstrates a need for

occupational therapy services to address social participation as a part of community reintegration.

Theory to Guide Protocol

Over time, it has become clear that acute intervention and rehabilitative efforts can produce varying outcomes for service members with serious polytrauma injuries. Multiple factors contribute to the effectiveness in which an individual returns to their desired level of function. Many military burn patients participating in rehabilitation, along with their families, are often faced with the additional challenges of adapting to new roles, learning how to compensate for functional losses, and are frequently forced into uncomfortable states of vulnerability. Since many military service members have unique challenges to their recovery, it is important that a multi-dimensional model be used to guide treatment. A biopsychosocial-spiritual model would be the most beneficial fit for the intended population as it considers not only physical factors related to rehabilitative outcomes, but also accounts for all other factors; psychological, social, and spiritual, that can impact a person's recovery.

Canadian Model of Occupational Performance and Engagement

The Canadian Model of Occupational Performance and Engagement (CMOP-E) is a prime example of a biopsychosocial-spiritual model that is also occupation-focused in its use. This model aligns with the direct needs of military burn patients as it acknowledges significant life disruptions that can create dysfunction within a person's personal and professional life (Krupa, 2016). The model also acknowledges that when an individual engages in meaningful occupations, it can bring about well-being, stability,

adaptation, life quality, and future possibilities (Krupa, 2016). These concepts parallel the reality that exists for many military burn patients in that they must overcome a multitude of challenges in order to return to civilian life. Spirituality is also a central concept when addressing the component of the person within the CMOP-E. This is relevant to this population during this phase of recovery as many military burn patients may benefit from addressing spiritual factors such as their sense of purpose and the meaning they attach to occupations they perform within their own lives. When engaging in occupations that are meaningful, oftentimes it creates conditions for improvement within an individual's health and well-being (Krupa, 2016). Creating interventions that are occupation-focused and client-centered will also help facilitate an easier and more successful transition back to civilian life for this population. In addition, occupational performance is established as an important aspect of rehabilitation in that it can be influenced by important client factors such as an individual's capabilities, characteristics, and beliefs. In the CMOP-E, "enablement and client-centered practice are the processes through which occupational therapists facilitate occupational performance and engagement" (Turpin & Iwama, 2011). In order to guide occupational therapy in practice, the CMOP-E is often used in conjunction with two related models, the Canadian Model of Client-Centered Enablement (CMCE) and the Canadian Process Practice Framework (CPPF). Together, these three models make up what is considered the Triple Model Framework. This framework was constructed with the assumption that health and well-being are supported through participation in occupations that are meaningful to the person (Krupa, 2016). This assumption is directly in alignment with the purpose as well as the desired outcomes of

the designed protocol. The framework also highlights ideas and practice approaches that increase the understanding of the psychological, emotional, and social factors related to human occupation (Turpin & Iwama, 2011). This is important for the intended population as these are the main factors contributing to challenges associated with occupational performance when returning to civilian life.

Canadian Model of Client-Centered Enablement

The CMCE is a practice model that identifies a list of enablement skills that are used by the therapist with the intent to enable occupations while addressing factors such as collaboration, power, equity, and justice (Krupa, 2016). This model is instrumental in developing a therapeutic relationship between military burn patients, their families, and the occupational therapist. This is particularly important as a collaborative relationship must be used with military burn patients and their families during the community reintegration phase of recovery for successful occupational performance to occur. The model also provides six client-centered occupation-based enablement foundations that were created with the purpose to provide equal opportunities for those experiencing disabilities within society and preventing them from being marginalized (Turpin & Iwama, 2011). While the CMCE is focused on the relationship between the patient and the occupational therapist, the CPPF provides the actions points to be used within the occupational therapy process.

Canadian Process Practice Framework

The CPPF is an eight-step action pathway for occupational therapists to use in order to deliver services in a client-centered way that focuses on the enablement of

occupations (Krupa, 2016). This practice framework was developed with the intent to create a more useful guide for individualized practice that would be considered client-centered. This practice model is appropriate for military burn patients and their families as it can be adapted to fit the individual. Within the process of the action steps, client participation and power sharing are emphasized (Krupa, 2016). Power Sharing is important to consider with the military burn population as they are experiencing that shift in identity due to their life-altering wounds as well as the loss of the identity of a soldier (Krupa, 2016). By supporting power sharing and client participation, this offers the patient a sense of control over their situation and provides them with the tools to rebuild a new identity that serves to increase their overall quality of life.

Evaluation Measures

Canadian Occupational Performance Measure

The Canadian Occupational Performance Measure (COPM) is an effective tool for an occupational therapist to use when deciphering what occupations are meaningful to their client and their client's views on their own performance in those occupations. This assessment is known as a tool for client-centered outcomes and goal setting to move forward in the therapy process (Sawada et al., 2020). The COPM can be instrumental in developing the occupational profile of a client, guide the therapeutic process, and keep the client involved in their own course of therapy. When working with military burn patients who are transitioning back into civilian life after a severe injury, this assessment would be helpful to identify the patient's points of concern and strengths in order to address them in their course of therapy.

Life Impact Burn Recovery Evaluation Profile

The Life Impact Burn Recovery Evaluation (LIBRE) profile is a multidimensional assessment that uses patient-report to evaluate social participation after a severe burn injury. Kazis et al. (2017), developed this assessment to consider burn injuries and social participation, as there had not been any previous assessments that focused on this aspect of the life of a burn survivor (Kazis et al., 2017). This assessment includes 6 different domains of social participation such as relationships with family and friends, social interactions, work and employment, social activities, romantic relationships, and sexual relationships (Kazis et al., 2017). After review and testing this assessment, the researchers found that the LIBRE has high reliability and is specifically designed for burn patients, unlike other assessments (Kazis et al., 2017). For someone to experience a traumatic injury, such as a severe burn, that can drastically change the way someone looks or change their individual needs, it can cause emotional and physical stress that may affect their social participation. This could be due to insecurities, fear, or physical features that may inhibit the client. The LIBRE can allow therapists to be specific when working on the social recovery process with the client in their return back to civilian life and their transition back into the community. This assessment is very client-centered and is geared toward the improvement of quality of life in burn survivors (Kazis et al., 2017).

Community Integration Questionnaire

When working with burn patients at the time of their transition back into the community, occupational therapists may use the Community Integration Questionnaire (CIQ) to assess the occupational barriers these patients may face. Originally, this

assessment was developed for neurologic injuries such as traumatic brain injuries. However, Gerrard et al. (2015) tested the validity and reliability of the CIQ with burn injury patients and found that it is appropriate and recommended for use with burn patients as they are being integrated into the community. Originally, the CIQ had 15 items on the questionnaire, however, the current researchers have reduced the questionnaire to 13 items that best suit the traumatic burn population (Gerrard et al., 2015). The questions that make up this assessment are geared toward self and family care in the home as well as social integration outside the home. While these are only a few of assessments that could be considered for use by an occupational therapist, these are ones that were identified in current literature for occupations identified.

Summary

Military members may be at high risk for acquiring traumatic burn injuries that can be life-altering due to a wide variety of combat variables. Once the initial trauma occurs a common process is used. First the wounded veteran is taken to a CSH in the combat zone where they are given immediate care. They are then transported to a hospital in a near-by location to receive care to ensure they will be stable enough to evacuate and be flown back to the USAISR where they will start their rehabilitation in an acute care and initial rehabilitation setting. Military burn patients have a very long process of recovery that has the potential to take years due to the effects of the burn as well as related comorbidities. Adverse effects from the burns and concurring comorbidities contributing to the extensive recovery may include but are not limited to pain, scarring and deformity, postburn itch, inhalation injuries, mild traumatic brain injuries and

psychosocial factors including PTSD and change in identity. These polytraumas and the extensive rehabilitation journey can have negative impacts on overall occupational performance and engagement, particularly during the community reintegration phase of recovery. Currently there is limited research and resources regarding the community reintegration phase of recovery for military burn patients and their families.

Occupational therapy has the capacity to address important client and environmental factors as well as the occupational challenges experienced by this population. The proposed treatment protocol addresses areas of community reintegration with increased deficits as a result of combat-related burn injury. These areas include quality of life, family roles, and impacted occupations such as work, driving, and social participation. Occupational therapists often operate from a biopsychosocial perspective, providing holistic care and interventions for physical, psychological, emotional, and social issues associated with disability and functioning (Brown & Hollis, 2013). It is from this same perspective the treatment protocol will be structured and facilitated using the Triple Model Framework. The Triple Model Framework highlights the importance of establishing a collaborative therapeutic relationship between the therapist and the client. This important relationship is created by focusing intervention on enabling occupations that are meaningful to the client, and ensures that the therapy process is client-centered.

This treatment protocol addresses the identified gaps in available treatment for military burn patients and their families during community reintegration. The goal or aim of this protocol is to improve the quality of life of the burned veterans and their families through occupational therapy skilled services during the rehabilitation phase of treatment.

It is anticipated that this protocol be made accessible to any occupational therapist working with a military burn survivor in any context of care.

The next chapter will explore the process in which the treatment protocol was designed, including an overview of the product with supporting literature, and a detailed report of procedures used in creating the protocol.

Chapter III: Methodology

The current scholarly project came about by a common interest in the veteran population by both occupational therapy students, Jessica Lambert, MOTS and Emma Chafin, MOTS. Another interest in burns was sparked after studying a unit on burn injuries in a graduate occupational therapy class, which then led to initial research identifying a need for an occupational therapy protocol for veterans who have experienced burns. After identifying this as a current need, the researchers landed on the topic of developing an occupational therapy protocol for improving quality of life and increasing occupational performance in veterans who have experienced a traumatic burn injury.

A literature review was conducted through online databases located within the School of Medicine and Health Sciences Library at University of North Dakota. The purpose of the literature review was to build a strong foundational understanding of knowledge related to military burn victims, their families, and the role of occupational therapy in related treatment. The following databases were utilized to gather literature: CINAHL Complete, PubMed, EBSCOhost Databases, Google Scholar, and OT Search. The following phrases were used to access pertinent information: burns, military burns, veterans, burn comorbidities, occupational therapy and burns, occupational therapy and military burns, occupational therapy and veterans, burn reconstruction, quality of life,

military care and combat wounds, military burns and rehabilitation, vocational rehabilitation and veterans, psychosocial and veterans, military burns and community reintegration, burns and intervention, comorbidities and military burns, combat casualties and burns, burn assessments, occupation based burn assessments, veterans and Canadian Model of Performance and Engagement.

Gaps in care for veterans with traumatic burn injuries were identified through the literature review. The gaps in the literature were then used to establish areas that needed to be addressed within the treatment protocol to be used in a community reintegration occupational therapy setting. It was identified that currently, there are limited established treatments for military burn patients that specifically look at meaningful occupations with family involvement, especially within the community reintegration phase of recovery. This product is an occupation-based treatment protocol that addresses the occupations and performance skills needed to successfully complete occupations that the literature has shown to be impacted and most important to treat during this phase of recovery. The desired outcome of the protocol is to increase the quality of life and occupational performance within military burn patients and their families.

This product was created using Google docs, email, Zoom, and online Microsoft Word to allow for both researchers to access the documents at the same time and to have online conversations to accommodate for being in separate locations. Guiding the course of action within the protocol is the *Occupational Therapy Process Framework* (4th eds.) which allowed for the protocol to maintain occupational therapy verbiage and focus. The researchers utilized the Triple Model Framework consisting of the Canadian Model

of Occupational Performance and Engagement, the Canadian Process Practice Framework, and the Client-Centered Enablement, to develop the protocol. The framework helped to develop the formatting of the protocol as well as the information and types of activities included in each of the sessions. The following chapter includes the full protocol with handouts following in the appendices, as well as a summary describing the limitations and further recommendations for the project.

Chapter IV: Product

INTRODUCTION TO PROTOCOL

The population of focus for this protocol is military burn survivors. Over the last two decades, many U.S. service members were exposed to extreme tactics of war that resulted in sustaining significant injuries (Besemann et al., 2018). Medical and rehabilitative interventions addressing the acute and sub-acute stages of injury have improved over the years, leading to an increase in survival for military members. With an increase in survival also means an increase in dealing with the residual effects of multiple injuries, multiple impairments, and multiple functional disabilities (Besemann et al., 2018). Military burn survivors specifically deal with a range of physical, psychological, social, and spiritual challenges that need to be addressed during their recovery stage in order to return to their desired occupations. Through an extensive literature review, these areas of occupational performance were identified as the most challenging for military burn survivors as they reintegrate back into civilian life:

- Driving
- Work
- Social Participation
- Identity Changes
- Spirituality
- Family Roles, Routines, and Expectations

This protocol was designed specifically to address each of these areas, as well as include the family unit within the occupational therapy process. It is important to note that during the review of literature, this population of individuals is often referred to as “patients” as well as “clients,” depending on the context of the information being provided. For the purposes of this protocol, the population of focus will be represented by the term “client.”

PURPOSE OF PROTOCOL

The purpose of this protocol is to provide skilled occupational therapy services to help facilitate a successful rehabilitation for military burn clients and their families as they reintegrate back into civilian life. The protocol was created with the intention that any occupational therapy practitioner regardless of level of experience, would be able to use it in practice to guide treatment for a client that falls within this population definition. The desired outcome of the protocol is to increase the quality of life and occupational performance within military burn clients and their families.

MODEL GUIDANCE

In the creation of this protocol, it was important that an occupation-focused model be used in order to support the use of occupation-based practice when implementing treatment for the intended population. Occupation-focused in the context of this protocol means that occupation is the central area of concentration, so that the immediate focus is on evaluating and changing a person's quality of occupational performance (Fisher, 2013). The Canadian Triple Model Framework for enabling occupation was used in order for this protocol to meet these expectations, as well as to meet the unique needs of military burn survivors and their families. Within the Canadian Triple Model Framework is the Canadian Model of Occupational Performance and Engagement (CMOP-E), the Canadian Model of Client-Centered Enablement (CMCE), and the Canadian Process Practice Framework (CPPF). The Triple Model Framework was chosen to use with military burn clients and their families as it provides an opportunity for individualized, client-centered care. It also promotes use of a variety of enablement skills and power-sharing with the client and requires their participation in reaching the intended outcomes of increasing health, well-being, and quality of life.

Table 1

Overview of the Canadian Model of Occupational Performance and Engagement

<table>
<tr><th colspan="2">CANADIAN MODEL OF OCCUPATIONAL PERFORMANCE AND ENGAGEMENT (CMOP-E)</th></tr>
<tr><td colspan="2">The CMOP-E is a conceptual model that depicts a dynamic interaction between occupations of self-care, leisure, and productivity, person components of physical, affective, cognitive, and spirituality, and environmental components of physical, institutional, cultural, and social. This dynamic relationship helps define how people experience meaning through the performance of their desired occupations (Krupa, 2016).</td></tr>
<tr><td>Main Components</td><td>The interaction between the person, occupation, and environment results in occupational performance. Occupational engagement enables the person to choose and perform their meaningful occupation within their various environments.
• Person
• Occupation
• Environment</td></tr>
<tr><td>Person</td><td>The performance components that facilitate interaction between the person and the environment within the model include:
• Affective
• Physical
• Cognitive
• Spirituality

Affective (feeling) is the domain that includes all social and emotional functions and includes both interpersonal and intrapersonal factors.
Physical (doing) is the domain that includes all sensory, motor, and sensorimotor functions.
Cognitive (thinking) is the domain that includes all mental functions and includes functions like perception, concentration, memory, comprehension, judgement, and reasoning.</td></tr>
</table>

<table>
<tr><td></td><td>Spirituality is the domain that is central to the model and the definition varies on the person, their environment, and the meaning it gives to their occupation.</td></tr>
<tr><td>Occupation</td><td>The components that make up occupation within this model include:
• Self-care
• Productivity
• Leisure

Self-care is defined as occupations that look after the self.
Productivity is defined as occupations that make a social or economic contribution or that provide for economic sustenance.
Leisure is defined as occupations for enjoyment.</td></tr>
<tr><td>Environment</td><td>The environmental factors considered along with their impact on the person within this model include:
• Cultural
• Physical
• Social
• Institutional

Cultural Environment depends on the individual and can fluctuate as one person is comprised of several different cultures.
Physical Environment is comprised of all the physical elements within the immediate proximity of person's natural environments.
Social Environment is composed of social groups and social norms.
Institutional Environment is comprised of the economic, legal, and political environments.</td></tr>
<tr><td colspan="2">The desired outcomes for the use of this model include:
• Occupational Performance
• Occupational Engagement

Occupational Performance is the process of carrying out the actions and tasks that are required in occupations.
Occupational Engagement is the idea that a person is actively involved in their occupations. This model requires that focus is beyond just performance and that the human experience of occupation is taken into consideration.</td></tr>
</table>

Sumsion, Tischler-Draper, & Heinicke (2016)

Table 2

Overview of the Canadian Model of Client-Centered Enablement

<table>
<tr><th colspan="2">CANADIAN MODEL OF CLIENT-CENTERED ENABLEMENT (CMCE)</th></tr>
<tr><td colspan="2">The CMCE provides guidance for the occupational therapy process when using the CMOP-E in practice. It identifies and develops a range of enablement skills that are important to enabling meaningful occupations. It also focuses on the relationship between the occupational therapist and the client, ensuring that the overall process is client-centered. Below is a list of the key skills and other related enablement skills utilized within the model.</td></tr>
<tr><th colspan="2">ENABLEMENT FOUNDATIONS</th></tr>
<tr><td colspan="2">The CMCE conveys that client-centered enablement is based on enablement foundations and the use of enablement skills in a collaborative relationship between the client and the occupational therapist. Enablement foundations are the “interests, values, beliefs, ideas, concepts, critical perspectives, and concerns that shape enablement reasoning and priorities (Townsend et al., 2007, p. 100). The six client-centered, occupation-based enablement foundations are:

○ Choice, Risk, Responsibility
○ Client Participation
○ Visions of Possibility
○ Change
○ Justice
○ Power-sharing (between client and therapist)</td></tr>
<tr><th colspan="2">KEY SKILLS</th></tr>
<tr><td>Adapt</td><td>This skill is mainly targeting altering occupations, altering the environment or selecting a different environment to enable occupation.

Related enablement skills: synthesizing, occupational analyses and proposing recommendations for adaptations</td></tr>
<tr><td></td><td>This skill could include raising awareness in others of problematic issues and promoting the need for these issues to be addressed.</td></tr>
</table>

Advocate	***Related enablement skills:*** *challenge, generate critical perspectives, prompt power sharing and empowerment, forming alliances and partnerships and developing lobby groups with others*
Coach	This skill includes encouraging clients to reflect upon and find their own motivations in their desired occupations. ***Related enablement skills:*** *engaging others in occupations, guide, challenge, hold accountable, mentor, pose powerful questions, reflect, reframe, support*
Collaborate	This skill is paramount in enabling power-sharing in client-centered practice. It involves working with people and not doing things to or for them. ***Related enablement skills:*** *cooperate, encourage, communicate, seeking multiple perspectives, promoting alliances and facilitating the resolution of differences through mutual negotiation*
Consult	This skill is necessary for practice with clients as well as in management, education and research roles. ***Related enablement skills:*** *advise, brainstorm options, confer, counsel, recommend, suggest, synthesize*
Coordinate	This skill is required to coordinate information, people, services, and organizations. It draws upon occupational therapist's ability to synthesize, analyze, and act on a broad range of information on occupations, person and environmental factors. ***Related enablement skills:*** *arrange, case coordinate/manage, integrate, allocate human, financial, space, and material resources, network, supervise, synthesize*
Design/Build	This skill encompasses many aspects that are linked to occupational therapists, including designing and building assistive technology or conceiving, rebuilding, fabricating, constructing products and environmental adaptations. This could also include designing a coaching strategy in order to adapt environments, advocating for social change or collaborating with interdisciplinary team members. ***Related enablement skills:*** *conceive, construct, create, develop, fabricate, envision, evaluate, plan, redesign, strategize*

Educate	This skill involves the provision of information associated with client education, but also expands to include understanding the educational philosophy, teaching, and learning principles. ***Related enablement skills:*** *facilitating rote, repetitive, and instrumental learning, guiding, prompting, listening, reflecting, encouraging, supporting*
Engage	This skill is central to client-centered practice and ensuring clients are involved in the therapy process. ***Related enablement skills:*** *build trust, challenge norm expectations, develop readiness and confidence, engage in "doing", involve, optimize potential*
Specialize	This skill is a process that occupational therapists are constantly developing in practice. It includes both skills development and an understanding of the relevant theoretical and philosophical perspectives behind the acquired skills. During this process they develop a range of skills. Some examples include activity analysis, therapeutic touch and positioning, hand therapy, and sensory-motor techniques. ***Related enablement skills:*** *facilitating body function, apply hands on techniques (cognitive approaches, driver rehabilitation, ergonomics, group therapy, psychosocial rehabilitation, sensory integration)*

Adapted from Krupa, T. (2016). Canadian Triple Model Framework for Enabling Occupation. *In Bruce and Borg's Psychosocial Frames of Reference: Theories, Models, and Approaches for Occupation-Based Practice* (pp. 123-133). Thorofare, NJ: Slack Incorporated and Turpin, M., & Iwama, M. K. (Eds.). (2011). Chapter 5: Canadian model of occupational performance and engagement. *Using occupational therapy models in practice a field guide.* Elsevier Ltd. doi: 10.1016/B97B-0-7234-3e9a-8.00005-X

Table 3

Overview of the eight action points from the Canadian Process Practice Framework

CANADIAN PROCESS PRACTICE FRAMEWORK (CPPF) EIGHT ACTION POINTS	
The CPPF was created to help guide occupational therapists towards enabling change in occupational performance and engagement. The framework utilizes eight key actions to enable clients to reach their occupational goals. Throughout the process the importance of client participation and power sharing are emphasized towards client goal attainment. The CPPF action points are typically used within conjunction of the CMCE enablement skills (Turpin & Iwama, 2011).	
ACTION POINTS	**KEY ENABLEMENT SKILLS & ACTIONS**
Step 1: Enter/Initiate	• Call to action: advocate for the client and occupational therapy to create a positive impression based on a referral, contract request, or the occupational therapists' assessment of real or potential occupational challenges • Consult to decide whether to continue or not with occupational therapy process • Educate and collaborate to establish and document consent
Step 2: Set the Stage	• Engage with the client to clarify their assumptions, expectations, values, and beliefs • Collaborate to find common ground or agree not to continue with services • Create/adapt healthy boundaries and expectations to the situation, build rapport and help build client readiness to engage in therapy process • Collaborate to identify priority occupational challenges and possible goals to address the challenges
Step 3: Assess/Evaluate	With client participation and power-sharing as much as possible: • Evaluate occupational status, hopes, and potential for change • Consult with the client, family, and/or treatment team, use specialized skills to evaluate and analyze spirituality, person and environmental influences on occupations

	• Analyze data and consider all perspectives for interpretation of findings • Create and document recommendations
Step 4: Agree on Objectives & Plan	With client participation and power-sharing as much as possible: • Collaborate to prioritize problem areas in occupational performance from assessment/evaluation • Design/build/plan occupational goals, timeframe, and resources within various contexts
Step 5: Implement the Plan	With client participation and power-sharing as much as possible: • Engage client through occupation to implement and document progress • Use program frame of reference as appropriate to achieve results
Step 6: Monitor & Modify	With client participation and power-sharing as much as possible: • Consult, collaborate, advocate, educate, and engage client, family, and others to enable success • Modify or redesign plan as needed
Step 7: Evaluate Outcome	With client participation and power-sharing as much as possible: • Re-evaluate occupational successes and challenges, compare with initial findings • Document and share findings and recommendations for next steps in process
Step 8: Conclude/Exit	With client participation and power-sharing as much as possible: • Communicate conclusion of interaction between client and therapist • Document conclusion/exit and share information for client transfer or re-entry

Adapted from Townsend, E. A. and Polatajko, H. J. (Eds.). (2007). *Enabling occupation II: Advancing an occupational therapy vision for health, well-being and justice*. CAOT Publications ACE.

EVALUATION PROCESS

The evaluation process is all about finding out what the client wants and needs to do, determining what they are currently able to do versus what they have been able to do in the past, and identifying supports and barriers to health, well-being, and participation (American Occupational Therapy Association [AOTA], 2020). For the purposes of this protocol, the evaluation process consists of the occupational profile and the analysis of occupational performance, which are then considered concurrently to determine the appropriate action for intervention.

The occupational profile identifies information about the client's needs, challenges, and concerns about performance in their desired occupations. The analysis of occupational performance focuses on collecting and interpreting information found to identify supports and barriers related to an individual's occupational performance and establish targeted outcomes (AOTA, 2020). The evaluation assessments listed below will be utilized during the evaluation process of each client, if deemed appropriate, to determine their occupational performance. Each assessment used during the evaluation process will be re-administered during Step 7: Evaluate Outcome of the final session of the protocol.

Keep in mind that the evaluation process will be influenced by client needs, practice settings, and the frame of reference or practice model chosen to guide practice. In order to facilitate the development of an occupational narrative that encompass the unique aspects of the intended population, as well as complements the Triple Model Framework, certain assessments might be more appropriate to use.

CLIENT/FAMILY INTERVIEW	Below are some example questions that may be appropriate in developing a client-centered occupational profile. ○ What parts of your life are currently going well? ○ What are you worried about with the return to a civilian lifestyle? What are you worried about with the return to your community with your new injuries? ○ How do you feel that your injury will change the way you perform your occupations? ○ What are your hobbies? Are there any other occupations or hobbies you would like to try? ○ As a family, are there any concerns you may have about this new transition?

	○ What are some resources that you know of in your community that are available to you and your family? ○ What are some things you are looking forward to now that your family is all together again? ○ Who would you like to reconnect with in your community? ○ Do you have access to public transportation or personal transportation? What is your confidence level in being able to effectively utilize these methods of transportation?
CANADIAN OCCUPATIONAL PERFORMANCE MEASURE (COPM)	The COPM is a client-centered outcome measure used to help clients identify and prioritize issues that are personally important. It can be used to detect changes in a client's self-perception of occupational performance over time in the areas of self-care, leisure, and productivity (Sawada et al., 2020). For best results, administer this assessment at the beginning of services to establish a baseline, use the results to help develop intervention goals and then re-administer to see if any gains have been made with the client.
LIFE IMPACT BURN RECOVERY EVALUATION (LIBRE)	The LIBRE is a multidimensional assessment that uses client-report to assess social participation after a burn injury. This assessment takes a look at 6 different aspects of social participation including relationships with family and friends, social interactions, work and employment, social activities, romantic relationships, and sexual relationships. The LIBRE should be used to identify the specific areas of social participation where the client is having difficulty to then address with interventions (Kazis et al., 2017).
COMMUNITY INTERGRATION QUESTIONNAIRE (CIQ)	The CIQ is an assessment that has 13 questions that are applicable to traumatic burn injury survivors. The questions on this assessment ask the client about various aspects of community integration including self-care, family care, and social integration. This assessment may be applied if the OT needs to dig deeper into these aspects of community integration to determine the needs of the client (Gerrard et al., 2015).
	The CCSF (See Appendix A) is a form created to help guide the development of the occupational profile using the concepts

CHALLENGES, CONCERNS, & SUPPORTS FORM (CCSF)	of the CMOP-E to bring to light any challenges, concerns, and supports throughout the client's transition into the community setting.

INTERVENTION PLAN: CLIENT

The following sessions have been created to use by occupational therapists in the community reintegration phase of recovery for military burn survivors. By utilizing the information from the Canadian Triple Model Framework and the research from the literature review, five sessions have been derived based on occupations that were found to be the most effected by the current population in their transition back to civilian life after suffering a traumatic burn injury.

- Driving/Community Mobility
- Work
- Social Participation
- Identity
- Spirituality

Each session may be tailored to the individual client and their family or caregivers by utilizing therapeutic use of self to make the sessions client-centered. These five sessions have a holistic design to provide best practice for each individual client.

SESSION 1: DRIVING/COMMUNITY MOBILITY	
Step 1: Enter/Initiate	**Enablement Skills** • Collaborate with client to develop a rapport, gather occupational information. • Advocate for client to receive therapy services if appropriate. **Actions** • Receive initial call to action (referral). • Identify client. • Identify stakeholders (family, caregiver). • Gather initial occupational narrative (include challenges & supports). • Parameters of referral are established (where, when for therapy). • Go over and provide forms for consent from client to receive services. • Therapist determines if taking on the referral is appropriate with present skillset. • Decision is made in collaboration with the client to begin services.
Step 2: Set the Stage	**Enablement Skills** • Educate client on purpose of occupational therapy, risks, and benefits of receiving services. • Engage client in finding out occupational narrative. • Collaborate with client to establish expectations of therapeutic relationship. **Actions** • Engage client by asking about their values and beliefs about driving and community transportation. • Explain the purpose of occupational therapy, the frequency and duration of visits; review ground rules of occupational enablement and discuss expectations of both therapist and client. • Explain nature and expected benefits of services to be provided, go over possible risks, identify course of action, explain consequences of not participating in therapy. • Receive necessary forms for informed consent and disclosure of information from client. • Suggest and explain appropriate assessment to gather more information (COPM, LIBRE, CIQ, and/or CCSF).

<table>
<tr><td rowspan="4">Step 3: Assess/ Evaluate</td><td>Enablement Skills</td></tr>
<tr><td>Engage with client throughout assessment process.
Coach the client through the assessments and help them to understand that all that matters is that they do their best.
Consult with the client on the outcomes of the assessments and help them to understand what they mean.</td></tr>
<tr><td>Actions</td></tr>
<tr><td>With client participation and power-sharing as much as possible:
Administer and analyze appropriate cognitive and visual assessments (MOCA, MVPT-4, etc.).
Consult with the client and family and use specialized skills to evaluate and analyze spirituality, person, and environmental influences on client’s identity.
Assess if the driver can make quick and safe decisions.
Consider the following: Can they functionally use the car controls? Can they follow directions or correctly utilize a map? Can they functionally utilize public transportation services and find their way in the community?</td></tr>
<tr><td rowspan="4">Step 4: Agree on Objectives & Plan</td><td>Enablement Skills</td></tr>
<tr><td>Collaborate with the client to develop a plan for the therapy session to include what is most important to the client.</td></tr>
<tr><td>Actions</td></tr>
<tr><td>With client participation and power-sharing as much as possible:
Discuss with client about driving with impairments and types of adaptive equipment that can be used if needed.
Discuss the effects of PTSD on driving.</td></tr>
<tr><td rowspan="4"></td><td>Enablement Skills</td></tr>
<tr><td>Identification of adaptive equipment, costs, and insurance reimbursement possibilities.
Educate the client on the possibilities of adaptive equipment and possible OT referral to a specific Driver’s Rehab Specialist.
Coach the client through the steps to get back to driving or how to find public community transportation.</td></tr>
<tr><td>Actions</td></tr>
<tr><td>With client participation and power-sharing as much as possible:</td></tr>
</table>

Step 5: Implement the Plan	• Identify the need for adaptive equipment or interventions to address visual perceptual skills and cognition.
	• Use clinical judgement to identify if the client is safe to drive or if they would benefit more from public community transportation. Note that the ultimate decision will be made by a physician, but recommendations can be made.
	• Order adaptive equipment for vehicle if necessary.
	    o Sunglasses, colored glasses, taped glasses
	    o Swivel chair
	    o Hand controls
	    o Left foot controls
	    o Extra handles or mirrors
	    o Handle extenders
	    o Seatbelt cushions or extenders
	    o Lifts
	    o Ramps
	• Practice coping skills to utilize while driving or using public transportation.
	    o Deep breathing techniques
	    o Muscle relaxation techniques
	    o Energy conservation techniques
	    o Pulling the car over to a safe place to take a rest break
	    o Utilizing maps or map applications to know where to go or as a reminder and peace of mind.
	    o Creating a schedule for when to leave for appointments based on how long it takes to get there.
	    o Create a schedule for public transportation and identify the times to be at the bus stop or times to call for a ride.
	    o Positive visualization/imagery
	• Introduce client to cognitive games and exercises to decrease mental fatigue while driving and to promote alert and safe driving skills.
	    o Word Searches
	    o Crossword puzzles
	    o Dot to Dots
	    o Mazes
	    o Sudoku
	    o Jigsaw Puzzles
	    o Computer/Tablet games/Applications (Ex: Flow Free, Brain Games, etc.)
	• Discuss and coach client for reducing level of offensive driving that they may have been used to in combat.

<table>
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Identify public transportation that is available in the community and educate the client on how to access the public transportation and how to advocate for needs.

Public bus systems
Taxi/Uber/Lyft services
Private hire transportation services
Hospital or medical service appointment transportation
Recreation center transportation services

The Association for Driver Rehabilitation Specialists website has some fact sheets available for public use to know what to look for and treat in drivers with specific conditions. This website may include other comorbidities to the burn injury such as anxiety, traumatic brain injury, vision impairments, spinal cord injuries, or amputations. This website also includes a downloadable copy of the best practice guidelines for the delivery of driver rehabilitation services.
The Association for Driver Rehabilitation Specialists website can be found at:
https://www.aded.net/page/510

The Association for Driver Rehabilitation Specialists website also offers some links to different resources available to use for adaptive equipment, payment options, and safety tips for driving interventions.
The Association for Driver Rehabilitation Specialists website can be found at:
https://www.aded.net/page/530

A resource for adaptive equipment is The Mobility Resource website which has information on types of equipment and sales as well as wheelchair accessible vehicles for sale. This site also has an option to rent equipment if the client would like to try out equipment before they make the commitment to purchase.
The Mobility Resource website can be found at:
https://www.themobilityresource.com/adaptive-driving-equipment/
</td></tr>
<tr><td rowspan="4">Step 6: Monitor & Modify</td><td>Enablement Skills</td></tr>
<tr><td>

Adapt the session and the activities to promote optimal engagement and success in the client.
Specialize the session to increase client-centeredness.

</td></tr>
<tr><td>Actions</td></tr>
<tr><td>With client participation and power-sharing as much as possible:

Track progress

</td></tr>
</table>

	• If therapist is a Certified Driving Rehab Specialist (CDRS), then practice driving on the road with modifications and adaptive equipment. • Suggest modifications to the client's routine or to their driving system.
Step 7: Evaluate Outcome	**Enablement Skills** • Collaborate with the client to assess what goals have been met and what works and does not work for them. • Consult with the client to develop a plan going forward. **Actions** With client participation and power-sharing as much as possible: • Re-assess with the cognitive assessments if needed. • Interview client and family members/caregivers for how driving/community mobility is going.
Step 8: Conclude/Exit	**Enablement Skills** • Educate the client on their progress and on other resources available for them to use in the future. • Coordinate with the client on an appropriate plan of action for future services or to consult with physician about terminating driving. **Actions** With client participation and power-sharing as much as possible: • Educate client on possibilities of a CDRS and refer to one in area if driving persists as a concern. • If therapist is a CDRS, then educate client on the possibility of increasing visits specifically for driving. • Educate client on other resources in community such as counseling, vision therapy, or continued occupational therapy for visual perceptual skills or cognitive skills. • Use therapeutic use of self to encourage and enable the client to increase their confidence in their abilities to drive in their community or to access public/private transportation to increase independence and overall quality of life.

<table>
<tr><th colspan="2">SESSION 2: WORK</th></tr>
<tr><td rowspan="4">Step 1:
Enter/Initiate</td><td>Enablement Skills</td></tr>
<tr><td>• Collaborate with client to develop a rapport, gather occupational information.
• Advocate for client to receive therapy services if appropriate.</td></tr>
<tr><td>Actions</td></tr>
<tr><td>• Receive initial call to action (referral).
• Identify client.
• Identify stakeholders (family, caregiver).
• Gather initial occupational narrative (include challenges & supports).
• Parameters of referral are established (where, when for therapy).
• Go over and provide forms for consent from client to receive services.
• Therapist determines if taking on the referral is appropriate with present skillset.
• Decision is communicated to the client.</td></tr>
<tr><td rowspan="4">Step 2:
Set the Stage</td><td>Enablement Skills</td></tr>
<tr><td>• Educate client on purpose of occupational therapy, risks, and benefits of receiving services.
• Engage client in finding out occupational narrative.
• Collaborate with client to establish expectations of therapeutic relationship.</td></tr>
<tr><td>Actions</td></tr>
<tr><td>• Engage client by asking about their values and beliefs about working.
• Explain the purpose of occupational therapy, the frequency and duration of visits; review ground rules of occupational enablement and discuss expectations of both therapist and client.
• Explain nature and expected benefits of services to be provided, go over possible risks, identify course of action, explain consequences of not participating in therapy.
• Receive necessary forms for informed consent and disclosure of information from client.
• Suggest and explain appropriate assessment to gather more information (COPM, QOLQ, LIBRE, CIQ, and/or CCSF).</td></tr>
</table>

Step 3: Assess/ Evaluate	**Enablement Skills** • Therapist specializes in administering and interpreting results of assessment(s). • Educate client on reasoning for assessments chosen. • Collaborate with client to determine their perceptions on how their occupational performance is affected by their occupational challenges through assessment. • Educate client on interpretation of assessment findings. • Coach client on utilizing self-evaluation to determine occupational challenges. **Actions** With client participation and power-sharing as much as possible: • Assess the client's job status, current skillset, wants/needs, and potential for change through interview, COPM, CCSF, and Career One Stop website that can be found at: www.*careeronestop.org.* • Consult with the client and family and use specialized skills to evaluate and analyze spirituality, person, and environmental influences on client's ability to work. • Analyze and interpret findings of assessments. • Discuss interpretation of assessment findings with client as well as appropriate recommendations and possible solutions to challenges. • Identify and confirm occupational challenges with client. • Perform other assessments that may be appropriate once occupational challenges are identified. Consider person factors, occupational, and environmental demands and the potential for engagement.
Step 4: Agree on Objectives & Plan	**Enablement Skills** • Collaborate with client to determine occupational performance and engagement goals. • Design a plan of action to obtain goals with the client. **Actions** With client participation and power-sharing as much as possible: • Therapist and client collaborate to determine and agree on work related occupational goals. • Therapist and client work together to determine objectives and plan to obtain work related occupational goals. • Consider and discuss potential person, environment, and occupational factors, their supports & challenges, and potential solutions.

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- Establish and finalize plan with client.

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<tr><td rowspan="4">Step 5: Implement the Plan</td><td>Enablement Skills</td></tr>
<tr><td>

- Collaborate with client to determine career interests and values and compare with client's current skillset.
- Consult with client in order to determine available job opportunities.
- Coach client to reflect upon abilities, available job opportunities and all steps involved to procuring employment.
- Assist client in designing/building professional resume, cover letter, and professional profile.
- Educate client on local resources for employment and vocational opportunities.

</td></tr>
<tr><td>Actions
NOTE: Depending on the client and their assessment findings, the areas in which they need intervention may vary. Below are work related intervention guidelines based on the stage at which the client may be and may span over the course of several sessions.</td></tr>
<tr><td>

With client participation and power-sharing as much as possible:

- Therapist and client collaborate to identify career interests, skills and work values using Career One Stop website found at: *www.careeronestop.org.*
    - Client to complete the Interest Assessment to determine career options that might meet their interests, option to complete the Mini Interest Profiler (30 questions) or for more in-depth assessment, visit the O*NET Interest Profiler (60 questions).
    - Client to complete the Skills Matcher Assessment to rate their level of experience with 40 work related skills in order to help match the individual's skillset to various career options.
    - Client to complete the Work Values Matcher in order to match the individual's values to their career in order to feel more satisfied and content, which in turn encourages job stability and retention.
    - Client to complete the Challenges & Supports Form to determine person-environment-occupational fit.
- Analyze the assessment results and collaborate with the client to identify jobs that would be appropriate to fulfilling the client's needs, wants, and abilities.

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- Identify if additional training, certification, or education is needed for client's preferred job choices.
- Therapist and client collaborate to begin searching for preferred available jobs.
  - Consult with client to determine level of confidence and ability in job searching. Educate client accordingly.
  - Client to identify and search list of potential job opportunities.
  - Example job search resources: Indeed.com, Monster.com, local vocational rehabilitation services, va.gov, USA.gov, various local job posting platforms.
- Therapist and client collaborate in creating a resume/career profile.
  - Client to create a LinkedIn profile.
  - Client and therapist to design/build resume and cover letter to reflect interest in specific job opportunity.
  - Client to participate in application process for chosen job opportunities.
- Therapist and client collaborate to establish effective interviewing skills.
- Therapist educates client on local resources and supports available.
  - Resume & Cover Letter building
  - Interview tips
  - Locate professional clothing (new or used)

</td></tr>
<tr><td rowspan="4">Step 6: Monitor & Modify</td><td>Enablement Skills</td></tr>
<tr><td>

- Coach client on dealing with challenges in obtaining job interview, with employer, or fellow employees.
- Engage client with encouragement to continue with development to obtain goals.
- Collaborate with client to determine if adjustments to plan need to be made.
- Adapt interview process or workplace demands to meet client's physical needs.

</td></tr>
<tr><td>Actions</td></tr>
<tr><td>

With client participation and power-sharing as much as possible:

- Therapist meets with client appropriate number of sessions allowed per month determined by need and/or insurance.
- Therapist and client determine if any adjustments need to be made to increase occupational performance.

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Accommodations are considered and addressed if needed, for example:

During interview process
Job duties (if approved by work facility)
Work environment
Ergonomics

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<tr>
<td rowspan="4">Step 7:
Evaluate
Outcome</td>
<td>Enablement Skills</td>
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<td>

Collaborate with client to determine if goals have been met.
Coach and educate client to evaluate strengths and gains made during therapy.

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<tr>
<td>Actions</td>
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<tr>
<td>With client participation and power-sharing as much as possible:

Therapist interprets reassessment results and determines with client if occupational goals related to work have been met.
If occupational goals have not been met, together the client and therapist determine if further occupational therapy is needed or if other service options need to be considered.
Client and therapist determine if no other work-related occupational challenges are being experienced.

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<tr>
<td rowspan="4">Step 8:
Conclude/Exit</td>
<td>Enablement Skills</td>
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<td>

Educate client about options for accessing occupational therapy services in the future.
Engage client in the process of concluding the therapeutic relationship.

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<tr>
<td>Actions</td>
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<tr>
<td>With client participation and power-sharing as much as possible:

Educate client on additional resources within the community that may be needed to further occupational performance in work.
Therapist and client end the therapeutic relationship if occupational goals have been met and no new goals have been identified.
Therapist provides the client with a summary of their progress and provides information for accessing occupational therapy services if needed in the future.

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<table>
<tr><th colspan="2">SESSION 3: SOCIAL PARTICIPATION</th></tr>
<tr><td rowspan="4">Step 1:
Enter/Initiate</td><td>Enablement Skills</td></tr>
<tr><td>• Collaborate with client to develop rapport, gather occupational information.
• Advocate for client to receive therapy services if appropriate.</td></tr>
<tr><td>Actions</td></tr>
<tr><td>• Receive initial call to action (referral).
• Identify client.
• Identify stakeholders (family, caregiver).
• Gather initial occupational narrative (include challenges & supports).
• Parameters of referral are established (where, when for therapy).
• Go over and provide forms for consent from client to receive services.
• Therapist determines if taking on the referral is appropriate with present skillset.
• Decision is made in collaboration with the client to begin services.</td></tr>
<tr><td rowspan="4">Step 2:
Set the Stage</td><td>Enablement Skills</td></tr>
<tr><td>• Educate client on purpose of occupational therapy, risks, and benefits of receiving services.
• Engage client in finding out occupational narrative.
• Collaborate with client to establish expectations of therapeutic relationship.</td></tr>
<tr><td>Actions</td></tr>
<tr><td>• Engage client by asking about their values and beliefs about social participation and if it is important to them.
• Explain the purpose of occupational therapy, the frequency and duration of visits; review ground rules of occupational enablement and discuss expectations of both therapist and client.
• Explain nature and expected benefits of services to be provided, go over possible risks, identify course of action, explain consequences of not participating in therapy.
• Receive necessary forms for informed consent and disclosure of information from client.
• Suggest and explain appropriate assessment to gather more information (COPM, LIBRE, CIQ, and/or CCSF).</td></tr>
</table>

<table>
<tr><td rowspan="4">Step 3:
Assess/
Evaluate</td><td>Enablement Skills</td></tr>
<tr><td>Engage with client throughout assessment process.
Coach the client through the assessments and help them to understand that all that matters is that they do their best.
Consult with the client on the outcomes of the assessments and help them to understand what they mean.</td></tr>
<tr><td>Actions</td></tr>
<tr><td>With client participation and power-sharing as much as possible:
Assess the client’s thoughts about social participation and what they may be nervous about or excited for in terms of social participation during the community reintegration phase.
Assess the social supports that are available to the client.
Consult with the client and family and use specialized skills to evaluate and analyze spirituality, person, and environmental influences on client’s identity.
The LIBRE is an assessment that could be helpful for identifying strengths and challenges with social participation after a severe burn injury.</td></tr>
<tr><td rowspan="4">Step 4:
Agree on
Objectives &
Plan</td><td>Enablement Skills</td></tr>
<tr><td>Collaborate with the client to develop a plan for the therapy session to include what is most important to the client.</td></tr>
<tr><td>Actions</td></tr>
<tr><td>With client participation and power-sharing as much as possible:
Choose social settings that are of interest to the client. (E.g., book club for someone who loves to read and discuss books; or, meeting up with a friend for coffee with a previously established friend or acquaintance).
Identify barriers they may be experiencing.</td></tr>
<tr><td rowspan="2"></td><td>Enablement Skills</td></tr>
<tr><td>Identify coping strategies to use in stressful social situations and make necessary adaptations.
Educate the client on social opportunities and effective social communication.
Coach the client on how to appropriately interact at the civilian level or to find social opportunities for them to participate in.</td></tr>
</table>

<table>
<tr><td rowspan="2">Step 5: Implement the Plan</td><td>Actions</td></tr>
<tr><td>With client participation and power-sharing as much as possible:
• Start with a warmup to build the client’s confidence.
    o Have the client think about and write down qualities they like about themself. Have them dig deep to see what other people like about them as well to build confidence.
    o Discuss favorite hobbies and activities and to ask the client why they enjoy those activities.
    o Discuss if the client can include friends or family members to join them for those activities.
• Discuss the findings from the assessments and identify what the client is uneasy about when returning to social participation.
    o Old friends
    o Family
    o Making new friends
    o Support groups
    o Veterans' groups
• Review coping strategies to utilize in uncomfortable social situations or when the client becomes stressed in a social situation.
    o Deep breathing
    o Counting
    o Muscle relaxation
    o Stress balls
    o Other personal coping strategies
• Affirm that it is acceptable to excuse oneself from a situation to take some deep breaths and collect thoughts to then return to the situation.
• Identify social events for the client to attend in the community.
• Identify accessibility throughout the community to promote social participation.
• Role play meeting new people or reconnecting old relationships.</td></tr>
<tr><td rowspan="4">Step 6: Monitor & Modify</td><td>Enablement Skills</td></tr>
<tr><td>• Adapt the session and the activities to promote optimal engagement and success in the client.
• Specialize the session to increase client-centeredness.</td></tr>
<tr><td>Actions</td></tr>
<tr><td>With client participation and power-sharing as much as possible:
• Check in with the client to see if they have attended any social events.</td></tr>
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- Ask them how the events went and if they have more events lined up for the current future.
- Make necessary changes to optimize social engagement for the client based on current and future needs.

</td></tr>
<tr><td rowspan="4">Step 7: Evaluate Outcome</td><td>Enablement Skills</td></tr>
<tr><td>

- Collaborate with the client to assess what goals have been met and what works and does not work for them.
- Consult with the client to develop a plan going forward.

</td></tr>
<tr><td>Actions</td></tr>
<tr><td>With client participation and power-sharing as much as possible:

- May use the LIBRE as a post-assessment.
- Ask the client their own perceptions of their social participation.

</td></tr>
<tr><td rowspan="4">Step 8: Conclude/Exit</td><td>Enablement Skills</td></tr>
<tr><td>

- Educate the client on their progress and on other resources available for them to use in the future.
- Coordinate with the client on an appropriate plan of action for future services or to end services.

</td></tr>
<tr><td>Actions</td></tr>
<tr><td>With client participation and power-sharing as much as possible:

- End social participation services or decide to continue services.
- Provide some encouragement to pursue social engagement.
- Answer any remaining questions.

</td></tr>
</table>

SESSION 4: IDENTITY	
Step 1: Enter/Initiate	**Enablement Skills** • Collaborate with client to develop a rapport, gather occupational information. • Advocate for client to receive therapy services if appropriate. **Actions** • Receive initial call to action (referral). • Identify client. • Identify stakeholders (family, caregiver). • Gather initial occupational narrative (include challenges & supports). • Parameters of referral are established (where, when for therapy). • Go over and provide forms for consent from client to receive services. • Therapist determines if taking on the referral is appropriate with present skillset. • Decision is communicated to the client.
Step 2: Set the Stage	**Enablement Skills** • Educate client on purpose of occupational therapy, risks, and benefits of receiving services. • Engage client in finding out occupational narrative. • Collaborate with client to establish expectations of therapeutic relationship. **Actions** • Engage client by asking about their values and beliefs about their own identity. • Explain the purpose of occupational therapy, the frequency and duration of visits; review ground rules of occupational enablement and discuss expectations of both therapist and client. • Explain nature and expected benefits of services to be provided, go over possible risks, identify course of action, explain consequences of not participating in therapy. • Receive necessary forms for informed consent and disclosure of information from client. • Suggest and explain appropriate assessment to gather more information (COPM, QOLQ, LIBRE, CIQ, and/or CCSF).

<table>
<tr><td rowspan="4">Step 3:
Assess/
Evaluate</td><td>Enablement Skills</td></tr>
<tr><td>• Therapist specializes in administering and interpreting results of assessment(s).
• Educate client on reasoning for assessments chosen.
• Collaborate with client to determine their perceptions on how their occupational performance is affected by their occupational challenges through assessment.
• Educate client on interpretation of assessment findings.
• Coach client on utilizing self-evaluation to determine occupational challenges.</td></tr>
<tr><td>Actions</td></tr>
<tr><td>With client participation and power-sharing as much as possible:
• Assess the client’s values, personality characteristics, challenges/supports, and potential for change through interview, COPM, CCSF, Values Worksheet, and Personality Test.
• Consult with the client and family and use specialized skills to evaluate and analyze spirituality, person, and environmental influences on client’s identity.
• Analyze and interpret findings of assessments.
• Discuss interpretation of assessment findings with client as well as appropriate recommendations and possible solutions to challenges.
• Identify and confirm occupational challenges with client.
• Perform other assessments that may be appropriate once occupational challenges are identified. Consider person factors, occupational, and environmental demands and the potential for engagement.</td></tr>
<tr><td rowspan="4">Step 4:
Agree on
Objectives &
Plan</td><td>Enablement Skills</td></tr>
<tr><td>• Collaborate with client to determine occupational performance and engagement goals.
• Design a plan of action to obtain goals with the client.</td></tr>
<tr><td>Actions</td></tr>
<tr><td>With client participation and power-sharing as much as possible:
• Therapist collaborates with client to develop therapeutic goals to address any identity challenges.
• Therapist and client work together to determine objectives and plan to obtain identity goals.
• Consider and discuss potential person, environment, and occupational factors, their supports & challenges, and potential solutions.</td></tr>
</table>

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- Establish and finalize plan with client.

</td></tr>
<tr><td rowspan="4">Step 5: Implement the Plan</td><td>Enablement Skills</td></tr>
<tr><td>

- Engage client in identifying their personal values and components of their identity.
- Collaborate with client to discuss the impact of their values, personality characteristics, and recent identity changes.
- Coach client on how to challenge and reflect upon reality vs. Ideal self-expectations.
- Educate client on cognitive strategies to assist in achieving therapeutic goals.
- Facilitate cognitive strategy techniques that are appropriate to client.

</td></tr>
<tr><td>Actions</td></tr>
<tr><td>

With client participation and power-sharing as much as possible:

- Therapist and client collaborate to identify values and personality characteristics.
    - Client to complete Values & Identity Worksheet (See Appendix B).
    - Client to complete free Personality Test found at the website: https://www.16personalities.com/free-personality-test.
    - Discuss findings of worksheet and test.
- Therapist and client collaborate to identify benefits and challenges of identity changes:
    - Active duty vs. civilian life
    - Post injury
- Therapist and client reflect on alignment of identity, values, and goals.
- Therapist educates client on strategies to help change perspective if desired by client.
- Therapist employs these strategies in following sessions if appropriate. Below are strategies that may be useful:
    - Motivational Interviewing
    - Mindfulness Meditation
    - Positive Psychology
    - Cognitive Restructuring

</td></tr>
<tr><td rowspan="2"></td><td>Enablement Skills</td></tr>
<tr><td>

- Coach client on dealing with challenges related to past and current identity changes.

</td></tr>
</table>

Step 6: Monitor & Modify	• Engage client with encouragement to continue with development to obtain goals. • Collaborate with client to determine if plan adjustments need to be made. **Actions** With client participation and power-sharing as much as possible: • Therapist meets with client appropriate number of sessions allowed per month determined by need and/or insurance. • Therapist and client determine if any adjustments need to be made to increase occupational performance.
Step 7: Evaluate Outcome	**Enablement Skills** • Collaborate with client to determine if goals have been met. • Coach and educate client to evaluate strengths and gains made during therapy. **Actions** With client participation and power-sharing as much as possible: • Therapist interprets reassessment results and determines with client if occupational goals related to identity have been met. • If occupational goals have not been met, together the client and therapist determine if further occupational therapy is needed or if other service options need to be considered. • Client and therapist determine if no other identity-related occupational challenges are being experienced.
Step 8: Conclude/Exit	**Enablement Skills** • Educate client about options for accessing occupational therapy services in the future. • Engage client in the process of concluding the therapeutic relationship. **Actions** With client participation and power-sharing as much as possible: • Therapist and client end the therapeutic relationship if occupational goals have been met and no new goals have been identified. • Therapist provides the client with a summary of their progress and provides information for accessing occupational therapy services if needed in the future.

<table>
<tr><th colspan="2">SESSION 5: SPIRITUALITY</th></tr>
<tr><td rowspan="4">Step 1:
Enter/Initiate</td><td>Enablement Skills</td></tr>
<tr><td>• Collaborate with client to develop a rapport, gather occupational information.
• Advocate for client to receive therapy services if appropriate.</td></tr>
<tr><td>Actions</td></tr>
<tr><td>• Receive initial call to action (referral).
• Identify client.
• Identify stakeholders (family, caregiver).
• Gather initial occupational narrative (include challenges & supports).
• Parameters of referral are established (where, when for therapy).
• Go over and provide forms for consent from client to receive services.
• Therapist determines if taking on the referral is appropriate with present skillset.
• Decision is made in collaboration with the client to begin services.</td></tr>
<tr><td rowspan="4">Step 2:
Set the Stage</td><td>Enablement Skills</td></tr>
<tr><td>• Educate client on purpose of occupational therapy, risks, and benefits of receiving services.
• Engage client in finding out occupational narrative.
• Collaborate with client to establish expectations of therapeutic relationship.</td></tr>
<tr><td>Actions</td></tr>
<tr><td>• Engage client by asking about their values and beliefs and their own definition of spirituality.
• Explain the purpose of occupational therapy, the frequency and duration of visits; review ground rules of occupational enablement and discuss expectations of both therapist and client.
• Explain nature and expected benefits of services to be provided, go over possible risks, identify course of action, explain consequences of not participating in therapy.
• Receive necessary forms for informed consent and disclosure of information from client.</td></tr>
</table>

	• Suggest and explain appropriate assessment to gather more information (COPM, QOLQ, LIBRE, CIQ, and/or CCSF).
Step 3: Assess/ Evaluate	**Enablement Skills** • Engage with client throughout assessment process. • Coach the client through the assessments and help them to understand that all that matters is that they do their best. • Consult with the client on the outcomes of the assessments and help them to understand what they mean. **Actions** With client participation and power-sharing as much as possible: • Through the use of assessments and building the occupational profile, discover the current level of spirituality of the client. • What has their spirituality looked like in the past?
Step 4: Agree on Objectives & Plan	**Enablement Skills** • Collaborate with the client to develop a plan for the therapy session to include what is most important to the client. **Actions** With client participation and power-sharing as much as possible: • After determining what is important and meaningful to the client, develop an individualized plan to address their spirituality.
Step 5: Implement the Plan	**Enablement Skills** • Help the client to identify what makes them truly happy and how spirituality plays a role. • Educate the client on spirituality and mindfulness. • Coach the client through spirituality and mindfulness practices. **Actions** With client participation and power-sharing as much as possible: • According to the results of the assessments, assign the client with daily or weekly readings that pertain to their spirituality. These readings can be articles, journals, devotionals, a holy book, or other resources to help guide the client's spirituality to improve quality of life. • Suggest possible spiritual practices such as meditation, prayer, attending support groups, counseling sessions, attending a church or

<table>
<tr><td></td><td>religious ceremony, spending time in the outdoors, journaling, or mindfulness logs.

Mindfulness Activity
Find a quiet place with no distractions. Be in silence. Close your eyes and take deep breaths. Breathe in 1-2-3-4, hold your breath 1-2-3-4, then exhale 1-2-3-4 (seconds). Continue breaths till your body feels relaxed. Focus on your breaths. How does it feel as you breathe in? How does it feel to breathe out? How does your body feel? Are you relaxed? Thank your body for all it can do and all it has done for you. Now, think to a specific time when you were truly very happy. What were you doing? Who were you with? Where were you? Bring yourself back to that moment of true happiness. Allow yourself to appreciate that happiness.
Daily Mantrum Activity
Have the client fill out the Spirituality Worksheet (Appendix C). They may discuss the worksheet with you as they fill it out to collaborate to develop a meaningful mantrum.
Other professional resources may be necessary to include in interdisciplinary treatment
Chaplain
Pastor
Spiritual leader
</td></tr>
<tr><td rowspan="4">Step 6: Monitor & Modify</td><td>Enablement Skills</td></tr>
<tr><td>Adapt the session and the activities to promote optimal engagement and success in the client.
Specialize the session to increase client-centeredness.</td></tr>
<tr><td>Actions</td></tr>
<tr><td>With client participation and power-sharing as much as possible:
Make appropriate changes to activities to individualize the client’s experience.
Monitor the client’s progress with their own spirituality over time.</td></tr>
<tr><td rowspan="3"></td><td>Enablement Skills</td></tr>
<tr><td>Collaborate with the client to assess what goals have been met and what works and does not work for them.
Consult with the client to develop a plan going forward.</td></tr>
<tr><td>Actions</td></tr>
</table>

<table>
<tr><td>Step 7:
Evaluate
Outcome</td><td>With client participation and power-sharing as much as possible:
• Identify if the client is pursuing spiritual opportunities.
• Does the client find importance or meaning to the activities or spiritual practices?
• Does the client feel more sound in their spirituality? Are they satisfied with their spirituality?</td></tr>
<tr><td rowspan="4">Step 8:
Conclude/Exit</td><td>Enablement Skills</td></tr>
<tr><td>• Educate the client on their progress and on other resources available for them to use in the future.
• Coordinate with the client on continuation of services or to conclude therapeutic relationship.</td></tr>
<tr><td>Actions</td></tr>
<tr><td>With client participation and power-sharing as much as possible:
• Provide education on what they should practice on their own to improve spirituality.
• Provide the client with local resources they have access to.
• Provide the client with other written or virtual resources.
• Conclude the session and thank the client for their participation.</td></tr>
</table>

INTERVENTION PLAN: FAMILY

Post combat injury affects not only the individual who has sustained the injury, but it can also have a profound impact on those within their family unit. It is important that intervention strategies include family members in order to address some of the challenges that occur post injury during the community reintegration phase of recovery. Including the family in the intervention process also increases the opportunity for success in meeting outcomes along the way. Family occupation-based groups provide a positive environment to promote parent and child engagement with each other, that in turn helps to promote health and occupational performance for the entire family unit (AOTA, 2020). In this portion of the intervention plan, Cole's 7 Steps are used to format the group sessions to create an optimal intervention experience that incorporates all members of the family unit. Some of the sessions were created to include children and others were not. Every session within this section can easily be modified by the therapist to ensure an appropriate client fit. The following sessions will be addressed below:

- Family Roles
- Partner Relationship
- Parenting Relationship
- Family Involvement in Care

SESSION 6: FAMILY ROLES

Session Description: This session is intended to address the changes that can occur in family roles, routines, and expectations during the community reintegration phase for military burn survivors. The session addresses items related to the following:

- Family Roles
- Family Well-being

Session Objective: By the end of the session, client and family members will be able to:

1. Identify challenges specific to their family unit in relation to parenting, marital relationship, and overall family dynamic.
2. Identify individual roles within their family unit.
3. Problem solve 3-5 solutions for addressing identified challenges.

Required Items: Family photos, Colorscape coloring pages, colored pencils/crayons, smart device (i.e. smartphone, tablet), provided worksheet, solo cups, rubber band, string

STEP 1: INTRODUCTION (10 min.)

- Warm up

Colorscape Coloring Pages (Herc Ltd., 2018)

Prior to the session, the therapist will ask the parents to bring in several pictures of the family having fun together. These pictures can be before and/or after the return of the family member with a traumatic burn injury. These pictures can either be emailed or sent directly to the therapist's phone for use in a coloring activity for the children. At the beginning of the session, the therapist will take a photo of the family together to add to the collection of photos. The therapist will then use those photos to transform to coloring pages in an application called, Colorscape (Herc Ltd., 2018). Once the application is opened, the therapist will follow the directions to upload the pictures and then create black and white coloring pages to print off and create a small coloring book for the children to use in the therapy session and to take home with them. This provides the children with something meaningful to them and allows them to see the good times they have had with their loved ones. It also provides them with an opportunity to color on pages that show the physical changes that have been made to their family member with a traumatic burn. This also gives the children an opportunity to address possible fears or apprehensiveness toward these physical changes and allows them to become more comfortable knowing that their loved one is still the same person they have always known and loved.

Step by step screenshot instructions for Colorscape are provided in Appendix D.

- Introduction Outline
  - State objectives of session
  - Introduce coloring pages for children
  - Worksheet (Appendix E)

STEP 2: ACTIVITY (45 min.)

<u>Family Roles</u>

Family Cup Stack
Solo cups, rubber band, string

Purpose: This activity is designed to demonstrate that each person plays an important role in the family unit.

Required Items: 6 solo cups, 1 rubber band that fits around solo cup, string cut into approximately 2-foot sections.

Instructions: Pieces of string will be tied around the rubber band distanced equally. The amount of strings to be tied should equal the amount of people in the family so that everyone has their own piece of string. The clients will stack cups into a pyramid by only using the string. If one person does not participate or does not support the string enough, it makes stacking the cup much more difficult for the rest of the family to stack.

Family Roles Worksheet
Purpose: This worksheet is designed for each member of the family to identify each of the roles they play in the family unit. It also allows for discussion about what roles are important to them, what roles they wish they did not have, or which roles they do not currently have but wished they had. This is a worksheet that is designed to be filled by each family member then discussed as a group.

Worksheet provided in appendix E. The number of worksheets printed should match the number of people in the family.

STEP 3: SHARING (15 min.)

Discuss the purpose behind the cup stacking activity and ask the family:

- What was most difficult about the activity?
- How were you able to work together to complete the activity?

- How do you think this relates to family roles?

Discuss the worksheet and allow for each person to share what they wrote. Allow for a group discussion.

STEP 4: PROCESSING (5 min.)

- What is going well in the family unit?
- What are some changes that can be made to promote optimal performance of the family unit?

STEP 5: GENERALIZING (5 min.)

- Relate the activity back to the daily life of the family unit.

STEP 6: APPLICATION (5 min.)

- How can necessary changes be made to promote optimal performance?

STEP 7: SUMMARY (5 min.)

Therapist to complete the following:

- Restate the objectives.
    - By the end of the session, client and family members will be able to:
        1. Identify individual roles within their family unit.
        2. Identify challenges and successes with family roles.
        3. Problem solve 3-5 solutions to addressing identified challenges.
- Relate session back to objectives, summarizing the important aspects of the group activity.
- Important to acknowledge the emotional content.
- Thank the group for their participation.
- End session.

SESSION 7: PARTNER RELATIONSHIP

Session Description: This session is intended to address the challenges that can occur within the partner relationship components of the family unit. It is designed to build upon variables that can influence relationship satisfaction.

Session Objectives: By the end of the session, client and family member will be able to:

1. Identify challenges experienced within their relationship.
2. Identify existing positive components within their relationship.
3. Complete the Relationship Appreciation Worksheet (See Appendix F).
4. Commit to an individualized behavior contract to help support relationship satisfaction (See Appendix G).

Required Items: Writing utensils, Relationship Appreciation Worksheet, and Behavior Contract

STEP 1: INTRODUCTION (5 min.)

- Warm-up
  - Individually, identify 2 positive aspects and 2 challenging aspects related to your relationship satisfaction post injury.
  - As a team, identify 2 positive aspects and 2 challenging aspects related to your relationship satisfaction post injury.
- Introduction Outline
  - State objectives of session.
  - Introduce Relationship Appreciation Worksheet.
  - Introduce Behavior Contract.

STEP 2: ACTIVITY (30 min.)

- Relationship Appreciation Worksheet
  - The therapist will discuss the importance of partner appreciation and then instruct participants to complete the worksheet independently.
  - Participants will prioritize the appreciation suggestions with 1 being the least important for the participant to receive within a relationship.
- Behavior Contract
  - The therapist will discuss the intended purpose of the contract and how it can be effective in holding each individual accountable to their relationship goals. Then the participants will complete the behavior contract independently.

- Prior to signing contract, the participants will need to discuss it with their partner before signing in order to ensure that they are on the same page for the goals, the reward, and the consequences of not fulfilling those goals.

STEP 3: SHARING (10 min.)

- Ask if client or family member would like to share their appreciate list results with their partner.
- Discuss results of the Relationship Appreciation Worksheets.
- Relate the worksheet back to the positive and challenging relational aspects identified in the warm-up if applicable.
- Discuss the Behavior Contract.

STEP 4: PROCESSING (3 min.)

- How easy or difficult was it for you to prioritize the suggested appreciation items? Explain why.
- How did you feel sharing the items you listed on your appreciation list?
- How did you feel when your partner shared the items on their appreciation list?
- How did you feel when completing the behavior contract?

STEP 5: GENERALIZING (2 min.)

- What did you learn about yourself from this activity?
- What did you learn about your partner from this activity?
- How does utilizing these strategies seem like it could benefit your relationship?

STEP 6: APPLICATION (3 min.)

- How is what you learned today significant to your relationship?
- How will you use what you learned today in the future?

STEP 7: SUMMARY (2 min.)

Therapist to complete the following:

- Restate the objectives.
  - By the end of the session, client and family members will be able to:
    1. Identify challenges experienced within their relationship.
    2. Identify existing positive components within their relationship.
    3. Complete the Relationship Appreciation Worksheet.
    4. Commit to an individualized behavior contract to help support relationship satisfaction.

- Relate session back to objectives, summarizing the important aspects of the group activity.
- Important to acknowledge the emotional content that was shared.
- Thank the group for their participation.
- End session.

SESSION 8: PARENTING RELATIONSHIP

Session Description: This session is intended to address the challenges that can occur within the parental components of the family unit. It is designed to build upon variables that can influence parental satisfaction.

Session Objective: By the end of the session, client and family member will be able to:

1. Identify challenges experienced within their parenting relationship.
2. Identify existing positive components within their parenting relationship.
3. Identify important parenting values using the Parenting Values Worksheet (See Appendix H).
4. Identify and complete effective stress management techniques to support parenting satisfaction using the Stress Management Handout (See Appendix I).

Required Items: Writing utensils, Parenting Values Worksheet, Stress Management Handout

STEP 1: INTRODUCTION (5 min.)

- Warm up
    - Individually, identify 2 positive aspects and 2 challenging aspects related to your parenting satisfaction post injury.
    - As a team, identify 2 positive aspects and 2 challenging aspects related to your parenting satisfaction post injury.
- Introduction Outline
    - State objectives of session.
    - Introduce Parenting Values Worksheet.
    - Introduce Stress Management handout.

STEP 2: ACTIVITY (30 min.)

- Parenting Values Worksheet
    - The therapist will discuss the importance of identifying parenting values and then instruct the participants in how to complete the worksheet.
    - The participants will complete the Parenting Values Worksheet.
- Stress Management Handout
    - The therapist will discuss the benefits that specific stress management techniques have on reducing stress.
    - The participants will review the handout and then engage in practicing a few of the techniques.

STEP 3: SHARING (10 min.)

- Discuss results of the parenting values worksheet.
    - What surprised you about identifying your parenting values?
- Discuss Stress Management techniques.
    - Was this activity difficult for you? And why or why not?

STEP 4: PROCESSING (3 min.)

- How did you feel participating in the stress management techniques?
- How did you feel creating and sharing the parenting values?

STEP 5: GENERALIZING (2 min.)

- What did you learn about yourself from this activity?
- What did you learn about your co-parenting partner from this activity?

STEP 6: APPLICATION (3 min.)

- How is what you learned today significant to meeting your parenting goals/values?
- How will you use what you learned today in the future?

STEP 7: SUMMARY (2 min.)

Therapist to complete the following:

- Restate the objectives.
    - By the end of the session, client and family members will be able to:
        1. Identify challenges experienced within their parenting relationship.
        2. Identify existing positive components within their parenting relationship.
        3. Identify important parenting values using the Parenting Values Worksheet.
        4. Identify and complete effective stress management techniques to support parenting satisfaction using the Stress Management Handout.
- Relate session back to objectives, summarizing the important aspects of the group activity.
- Important to acknowledge the emotional content that was shared.
- Thank the group for their participation.
- End session.

SESSION 9: FAMILY INVOLVEMENT IN CARE

Session Description: This session is intended to address related items that may occur within the family unit post injury, including:

- Post injury education
- Home management
- Family routines

Session Objective: By the end of the session, client and family members will be able to:

1. Understand more about scar management techniques.
2. Gain a better understanding of their role within the client's post injury treatment and recovery.
3. Create a weekly schedule that facilitates health-promoting routines and daily activities to support family life.

Required Items: Prior to session ask the parents to bring a list of upcoming appointments, child activities, family obligations, etc., writing utensils, Scar Management handout, Weekly Schedule template

STEP 1: INTRODUCTION (5 min.)

- Warm up
  - Provide and discuss open questions about post burn injury and related factors.
- Introduction Outline
  - State objectives of session.
  - Introduce Scar Management handout (See Appendix J).
  - Introduce Weekly Schedule template (See Appendix K).

STEP 2: ACTIVITY (30 min.)

- Scar Management
  - The therapist will provide the family with education about scar formation and scar management techniques.
  - The participants will practice several of the scar management techniques.
- Weekly Schedule

- The therapist will discuss the benefits that creating a weekly schedule can have on involving the family in post injury care of their loved one.
- The participants will complete a weekly schedule template.

STEP 3: SHARING (10 min.)

- Discuss the Scar Management handout and any additional questions.
  - What surprised you about the information provided to you today?
- Discuss the Weekly Schedule
  - Was this activity difficult for you? And why or why not?

STEP 4: PROCESSING (3 min.)

- How do you feel about participating in the scar management of your parent or partner?
- How did you feel creating the weekly schedule for your family?

STEP 5: GENERALIZING (2 min.)

- What did you learn about yourself from this activity?
- What did you learn about your family and partner from this activity?

STEP 6: APPLICATION (3 min.)

- How is what you learned today significant to being involved in your family member's care?
- How will you use what you learned today in the future?

STEP 7: SUMMARY (2 min.)

Therapist to complete the following:

- Restate the objectives.
  - By the end of the session, client and family members will be able to:
    1. Understand more about scar management techniques.
    2. Gain a better understanding of their role within the client's post injury treatment and recovery.
    3. Create a weekly schedule that facilitates health-promoting routines and daily activities to support family life.
- Relate session back to objectives, summarizing the important aspects of the group activity.
- Important to acknowledge the emotional content that was shared.
- Thank the group for their participation.
- End session.

Chapter V: Summary

Purpose and Overview

The purpose of this product is to create a resource tool for occupational therapy practitioners to use in addressing the challenges that occur in military burn clients. The intention is to provide information on the types of challenges these clients may face and to suggest how to navigate those challenges through the assessment and intervention process. This product provides suggestions for intervention sessions regarding driving and community mobility, work, social participation, identity changes or challenges, spirituality, family roles, partner relationships, parenting relationships, and family involvement in continuation of care. All of these challenge areas have been identified throughout the literature review which demonstrates a need for addressing these issues within this population. The Canadian Model of Occupational Performance and Engagement (CMOP-E) is beneficial for the intended population as it considers not only physical factors related to rehabilitative outcomes, but also accounts for all other factors, psychological, social, and spiritual, that can impact recovery. For the purpose of this product, the Canadian Model of Client-Centered Enablement and the Canadian Process Practice Framework are used in conjunction with the CMOP-E which make up the Triple Model Framework. This framework was constructed with the assumption that health and well-being are supported through participation in occupations that are meaningful to the

person (Krupa, 2016). This assumption is directly in alignment with the purpose and desired outcomes of the designed protocol. The framework helps to provide an understanding of the psychological, emotional, and social factors related to human occupation (Turpin & Iwama, 2011).

Limitations

After creating this protocol a few limitations were identified. First, the treatment protocol is designed to be used with military burn clients and their families for occupational performance areas identified and does not specifically address the myriad of other needs that other military veterans may have. Second, although the magnitude of impact is becoming clearer that combat has had on active military members, it is still unclear the long-term effects it may have on their family unit. The protocol itself was created with the intention that it be tailored to fit the specific needs of the intended client in mind, otherwise it may not be as effective to use within the intervention process.

The third limitation is that the treatment protocol may require multiple sessions. The sessions were created to be used individually if needed, depending on the client's needs, but to be used in totality would expand the intervention process into nine sessions. Depending on the number of visits dictated by insurance could impact the number of sessions available to the client.

The final limitation is the lack of evidence supporting occupational therapy's role in working with military burn clients and their families during the rehabilitation phase of community reintegration. The treatment protocol itself is created from evidence on the impact of combat related injuries and comorbidities as well as existing programs and

services already available to this population. The role of occupational therapy is identified from this information revealed within the literature review to address and optimize quality of life and occupational performance of military burn clients.

Recommendations

It is recommended that this product be fit into community reintegration programs through a hospital, outpatient facility, home health programs, or through the veteran's administration. This protocol is designed to be tailored to the specific needs of the client through the occupational profile which is obtained through assessments, interviews, and observations. Further development or revisions of this product may be required if additional sessions would benefit the individual client. Lastly, it is recommended that this protocol be evaluated for effectiveness once it is implemented.

Conclusion

There is a need for continued research and occupational therapy services to address the needs of military burn clients and their families within the rehabilitation process specific to community reintegration. This treatment protocol brings awareness to this population and the role that occupational therapy can play in addressing occupational performance barriers with the intended outcome of increasing performance as well as quality of life. Occupational therapists can use this protocol as a resource to individualize intervention and create an overall client-centered approach to care.

Appendix

Appendix A

CHALLENGES, CONCERNS, & SUPPORTS FORM	
List the following applicable factors to identify client specific challenges, concerns, & supports to create an occupational profile.	
PERSON	
Spirituality	
Cognitive	
Physical	
Affective	
OCCUPATION	
Self-care	
Productivity	
Leisure	
ENVIRONMENT	
Institutional	
Cultural	
Physical	

Social	

Appendix B

VALUES & IDENTITY WORKSHEET

Below is a list of values. Circle the values that stand out for you as the most important, then rank them from 1 to 10, with the number 1 being your top value. You can also add your own values if they are not provided in the list.

Value	Ranking
Family	
Leadership	
Spirituality	
Financial Stability	
Happiness	
Relationships	
Fitness	
Being a Provider	
Being Challenged	
Work-Life Balance	
Hobbies	
Health	
Independence	
Helping Others	
Forgiveness	
A Positive Attitude	
Self-Growth	
Work	
Creativity	

ANSWER THE FOLLOWING QUESTIONS

1. What defines who a person is?
____
____
____

2. What defines self-worth in a person?
____
____
____

3. Describe 3 situations that have happened that have made you who you are (positive or negative).
____
____
____

4. How do your values align with your current actions?
____
____
____

5. Of the values listed, which do you spend more time on and why?
____
____
____

6. What can change in your life to align with your values?
____
____
____

Appendix C

SPIRITUALITY WORKSHEET

What activities make you truly happy?

____

____

____

Who makes you truly happy?

____

____

____

What are some spiritual practices that you currently participate in?

____

____

____

What are spiritual practices that you used to do that you no longer participate in?

____

____

____

What are some spiritual practices that you wish you participated in?

____

____

____

What is your current level of satisfaction with your spirituality?

____

____

____

What is one thing that you can do every day to improve your own spiritual well-being?

____

____

____

When will you choose to participate in this activity?

____

____

____

What do you need in order to complete this daily activity?

____

____

____

What will be your daily reminder to participate in this daily activity?

____

____

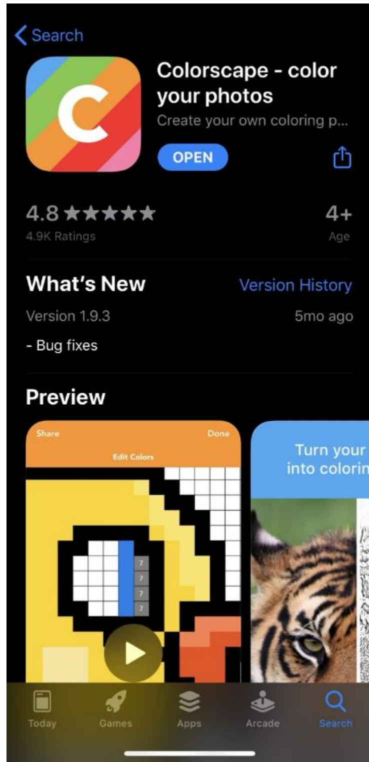
____

Develop a mantra that can describe your spirituality through your own perspective. What makes you who you are spiritually?

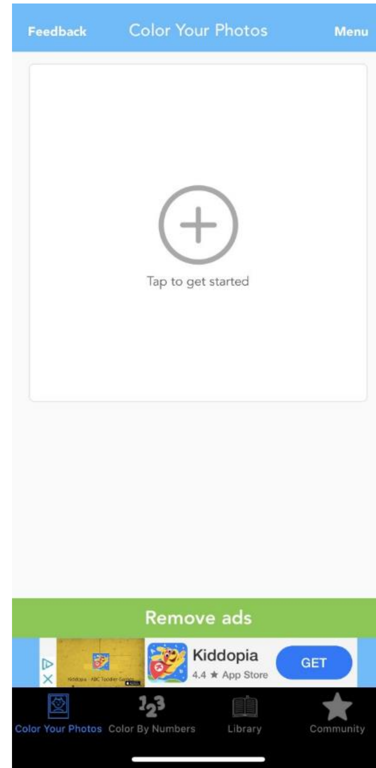
Appendix D

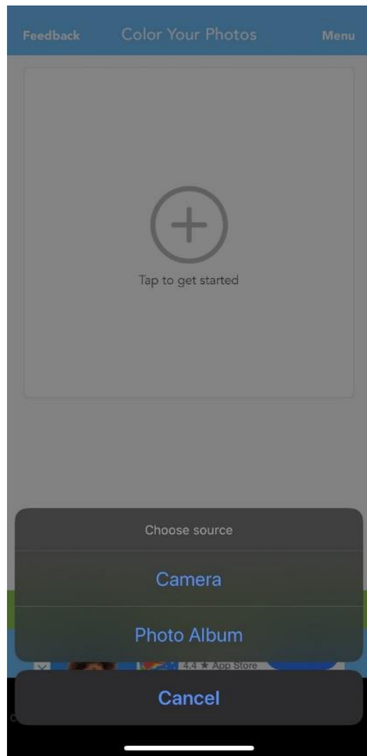
COLORSCAPE COLORING PAGES

1.



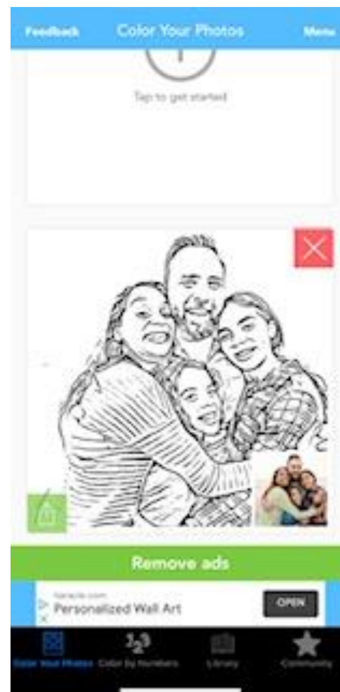
2.



3. 

4.

5.

6. 

7.

Herc Ltd. (2018)

Appendix E

FAMILY ROLES WORKSHEET

What is a Role?
"A function or part performed especially in a particular operation or process" (Mirriam-Webster, n.d.).
Roles are one aspect of occupational identity (i.e., who a person or a group of individuals believes themselves to be based on their occupational history and desires for the future) and have been historically defined assets of behaviors expected by society and shaped by culture and context; they may be further conceptualized and defined by a client [person, group, or population] (Kielhofner, 2008; Taylor, 2017). Certain roles are often associated with specific activities and occupations such as a parent feeding their child (Kielfhofner, 2008; Taylor, 2017).

What roles do you currently hold in your family unit?

____

____

____

What roles are most important to you?

____

____

____

What roles would you like to change?

____

____

____

How do you feel that you uphold these roles?

____

____

____

In what ways do you feel like you are succeeding in your family roles?

____

____

____

In what ways do you feel like you need to improve in your family roles?

____

____

____

What would you like your family to know about your roles?

____

____

____

Appendix F

RELATIONSHIP APPRECIATION WORKSHEET

When in a relationship, it can often be common to take the things we appreciate about our partners for granted. Practicing appreciation for them on a daily, weekly, and/or monthly basis is a good way to reconnect to the things you love about them while simultaneously showing them your appreciation. Below are some examples of ways to practice appreciation of your partner. Putting the following suggestions into practice could help improve or continue to strengthen the quality of your relationship.

Rate the suggestions 1-8, with 1 being the least important for you to receive within a relationship.

- Give them a compliment. ___
- Pay attention when they are talking to you. ___
- Show them you are interested in their life. ___
- Surprise them with something they like. ___
- Compromise when appropriate. ___
- Help with non-preferred chores. ___
- Be reliable and follow-through. ___
- Write down 5 things you appreciate about them and share. ___

Additional suggestions not listed:

-
-
-

TIME TO PRACTICE!

List 5 things that you appreciate about your partner:

1. ____
2. ____
3. ____
4. ____
5. ____

Appendix G

BEHAVIOR CONTRACT

Based on an awareness of my own personal behavior, I, ____________________________ have decided to set the following goals. I will strive to achieve these goals between the following dates, ____.

My goals are:

____
____
____
____

The advantages to achieving these goals are:

____
____
____
____

The difficulties for me in doing this are:

____
____
____
____

The ways that I will try to accomplish these goals are:

____
____
____
____

If I have achieved these goals by ________________________, I will reward myself and my partner by ____

____
____
____

If I fail to meet these goals, I will forfeit this reward.

Signed: ____

I, ____, have reviewed this contract and I agree to discuss the experience involved in accomplishing or not accomplishing this health behavior improvement with my partner on _________________________.

Appendix H

PARENTING VALUES WORKSHEET

What are your top 5 values in relation to being a parent?

1.
2.
3.
4.
5.

Now describe why each value you listed is important to you.

1. ____
   ____
2. ____
   ____
3. ____
   ____
4. ____
   ____
5. ____
   ____

Do your current parenting abilities align with these values? Why or Why not?

____
____
____
____

What do you think you could change to align more with these parental values?

____
____
____
____

Appendix I

STRESS MANAGEMENT TIPS

What do you currently do to deal with stress?

____

____

Here are some examples of how to deal with stress before it becomes unmanageable:

- ❑ Establish a support system
- ❑ Do fun things with the kids
- ❑ Create a daily routine or schedule
- ❑ Take a quick break
- ❑ Deep breathing
- ❑ Meditation
- ❑ Practicing mindfulness
- ❑ Daily gratitude list for at least 21 days

PRACTICE DAILY GRATITUDE LIST

List 5 things that you are grateful for about your family:

1. ____
2. ____
3. ____
4. ____
5. ____

Appendix J

SCAR MANAGEMENT

Common Types of Scar Management Techniques:

Pressure Garments	Commonly worn while the wounds are still healing in the acute phase.
Topical Creams/Scar Ointments	It is important to keep the scar moist to allow for optimal skin stretch and scar healing. By keeping moisturizers and ointments on the scar, it helps to keep the scar flexible and may improve range of motion if it is over a joint. (May avoid "cooling" gels due to possible increase in itch effects [Nedelec & LaSalle, 2018])
Silicone or Gel Sheets	Silicone can help to improve the look and feel of scars and to improve their elasticity.
Range of Motion	Active range of motion and passive range of motion techniques are used specifically for scars over joints. By working on range of motion of the affected joint, it ensures that the scar tissue will stretch with the joint to improve its flexibility and allow for functional range.
Massage	Massaging a scar is important to improve the look of the scar and to improve its elasticity for functional movement.
Diet	Vitamin C is a big component in soft tissue healing which could help with the healing of scars. Foods that are high in protein are also recommended for the healing of scars and wounds.

Appendix K

WEEKLY SCHEDULE TEMPLATE
Fill out this schedule with your appointments, family obligations, work, school, chores, etc. It is recommended to use a different colored pen for each person on the schedule. It may also be recommended to complete a similar chart onto a poster board that could be hung in the house.

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
6am							
7am							
8am							
9am							
10am							
11am							
12pm							
1pm							
2pm							
3pm							

4pm							
5pm							
6pm							
7pm							
8pm							
9pm							
10pm							
11pm							
12am							

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