
TECHNOLOGY

SPECIAL INTEREST SECTION QUARTERLY

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The Task Performance Position: Providing Seating for Accurate Access to Assistive Technology

■ Karen M. Kangas, OTR/L

Much of the equipment we use today for seating was originally developed for persons with spinal cord injuries, especially persons with quadriplegia. These systems have subsequently undergone adaptation for use with children and adults with spastic quadriplegia. As we all know, these two client groups are vastly different. The biggest difference is that one group has had damage to the spinal cord that usually results in a loss of sensation, whereas the other group has had damage to a higher level of the central nervous system, most often the motor cortex, but maintains sensation. These two groups are not comparable, especially regarding seating. This article focuses on persons who have not had a spinal cord injury but who do have hypertonicity, spasticity, choreoathetosis, athetosis, ataxia, hypotonicity, or a combination of these conditions.

In addition, when discussing seating and access, the word *access* is both a verb and a noun. We want to assist the person *accessing* (the verb) a piece of equipment to perform a task (e.g., talking, writing, driving). The equipment he or she will use requires *access* (the noun) (e.g., a switch, a voice, a mouse emulator). Thus, seating for access means that we want a person to perform a task (while seated) with some method of access to then access a device.

Seating for Task Performance: The Underlying Concept

Seating for access in the past has either been exactly the same as “static seating” or has been overly restrictive or paradoxically unstructured. Seating for task performance requires new skills in providing seating that works.

From the Editor

This is the first issue of the new and revised *Technology Special Interest Section (TSIS) Quarterly*, which is a joint issue with the *Physical Disabilities Quarterly* on positioning. Each subsequent *TSIS Quarterly* will be a joint issue with other SISs, which reflects the mission of the TSIS: To provide awareness and basic knowledge of assistive technology in the context of practice (SIS) areas rather than to provide advanced knowledge in assistive technology. The *TSIS Quarterly* will continue to maintain high standards for all articles, but the information will be provided in context and to a broader audience. We welcome your feedback and hope that the *TSIS Quarterly* continues to be a useful resource for you. ■

Michelle L. Lange, OTR, ABDA, ATP

For any isolation and adequate use of an extremity in a graded, controlled movement (for accurate and competent use in task completion), pelvic stability with pelvic weight bearing must occur, and the person must control this himself or herself. This stability of the pelvis does not involve a position of immobility but rather involves a position that allows a range of controlled (limited, graded) pelvic mobility.

Pelvic stability involves a position of actively “holding still” rather than being passively restricted. Pelvic stability does not involve a position of relaxation nor of stillness but rather involves a position of “coactivation” or an “active” holding. In short, the body must allow muscle lengthening and controlled shortening simultaneously to allow controlled holding. This active holding will allow more active movement than an extremity will control.

This pelvic posture is not simply a musculoskeletal posture but rather is a movement of the body that includes an ongoing interaction of numerous systems, including the musculoskeletal, neuromuscular, circulatory, respiratory, gastrointestinal, and endocrinological systems. These physiological systems become integrated and facilitated, and then the client can use and develop them with experience. This experience is specifically for a particular task and its performance.

Pelvic girdle stability is necessary for shoulder girdle mobility. However, this relationship is critically related to weight bearing and movement. Pelvic girdle stability combined with shoulder girdle mobility provides a foundation from which to control and move the head. This same relationship also allows for control of the upper extremities.

When persons are not mobile, they have little active experience with gravity. These persons (especially those with hypertonicity) in their current seating systems are most often asked to remain even more stable by “not moving.” These persons subsequently, and not surprisingly, have difficulty learning how to integrate various sensorimotor skills, especially eye-hand-head coordination. In fact, restricted (static symmetrical) seated postures (i.e., those that do not allow for pelvic stability) do not allow the person to use the head or hands adequately to perform a task.

Generally, a seated position for task performance is one in which a person's shoulders and head are in front of the pelvis rather than in line with the pelvis or behind the pelvis. Feet are on the floor, are weight bearing, and are not necessarily symmetrical. A knee may be lower than a hip, and one knee may be higher than the other (in alignment with the hip). The person uses and holds the knees at a posture of less than 90° of flexion below or under the body. Weight bearing is not symmetrical, and both the hamstrings and the quadriceps musculature are coactive. One could describe this posture as the posture one uses to get up out of a chair but without getting up (leading with the head, the pelvis in an anterior tilt, the legs weight-bearing, and the shoulder girdle in front of the pelvis). As the person gains experience with this posture, he or she can initiate movement and maintain and replicate it as a task or routine would suggest.

In contrast, persons with increased tone are often in a reclined posture with a wedged or “antithrust” seat (placing the knees higher than the hips, decreasing the hip angle to less than 90°, and forcing the pelvis into a static posterior tilt). Their feet are off the floor and raised onto footplates smaller than their feet. Their lower extremities are symmetrical and abducted, usually with the knees at a position wider than the hips rather than in line with the hips. The knees are located at a position of more than 90° of flexion, although the feet may be parallel to the floor. This posture prevents any weight bearing on the thighs and on the feet and does not allow the pelvis to tilt anteriorly. In fact, the lower extremities must not be in line with the hips and certainly must not touch each other.

Why does this matter? Body control is interpreted and performed when the body understands its relationship to gravity, primarily through the activation of the vestibular system. The ability to bear weight (interpreted through motor proprioceptors) and to react stably yet dynamically to gravity is critical to our every movement. In fact, the movement of the pelvic girdle (the shift of the pelvis into an anterior posture and the subsequent active weight bearing in the lower extremities) is an alerting reaction to the musculoskeletal system. If a person wants to perform a task, then the pelvis must shift and send messages to both the shoulder girdle and the head that gravity is supporting the activity and that the body is ready to work. This shift of the pelvis forward requires more power from the body and asks the body to “kick in tone” in extension. This trunk extension lends additional power to the pelvis for increased stability, to the lower extremities for weight bearing, and to the shoulder girdle and head for movement. In short, the pelvis and its movement signal the entire body to become ready to perform a task by encouraging an increase in tone, power, and alertness.

Consequently, when a person needs to learn a new task, he or she must assume a learning position (task performance). Once the person has assumed this position, he or she can more easily assume, practice, and obtain access. For persons who cannot obtain this posture, seating can assist them in assuming it.

For example, consider a young girl with athetoid cerebral palsy who has lower tone in the trunk and higher tone in the extremities. In her current seating system, a tall back, a wedged (antithrust) seat, foot straps at both heels and toes, a separate chest “butterfly” vest, and a large head support completely support her trunk and lower body. She could not see to use a hand switch (because of neck extension), and she could not use a switch behind her head because she was bearing weight on her headpiece (and would not be able to release the switch). As she attempted to reach a switch, her pelvis would thrust posteriorly, she would attempt to push on her legs and feet, and her arms would fly up. She was determined to have “too much thrust, too much tone, and inconsistent with switch access.” Why? As she asked her body for increased power and attempted to move her pelvis, the only place the pelvis could move was posteriorly because of her seated posture. This power or increased tone forced rather than helped her head and feet against the head piece and footplates, further trapping her within her seating system. The more she worked, the more tone she required, and the more “pushing” and extensor tone occurred, and success at reaching a switch was impossible.

However, when her seating was changed to allow her to perform a task, her tone was able to provide adequate power for real task use. The seating was changed by first placing her into a carved, firm seat with deep thigh channels, which provided her legs with tactile and kinesthetic input. The seat itself was in a very subtle anterior tilt. The footplates were lowered simply to graze the bottom of the feet. The back was replaced with one of shoulder height. Deeper trunk positioners close to the trunk were added (not curved but simply available as a cue to her trunk and deep enough when she would bring her trunk forward). The chest strap and the headpiece were removed. Velfoam straps (Therapro, Framingham, MA) were added in a simple posture around the knees and in front of them.

This seating allowed some containment of the pelvis and support at the knees and prevented her from pushing off of the footplates when she initiated back extension for head control. Trunk support existed but was not constricting. She was now able to move and see. She had more control of her body and was ready for the task. She did not use a head support. In fact, head control was evident, whereas previously it was questionable.

The 90/90/90 Position: Why It Will Not Work for Task Performance

This position originally resulted from the belief that, when the hips, knees, and ankles could all be at a 90° angle, the head and trunk would naturally assume a midline position. Presumably, this totally symmetrical posture would provide head control and control of tone and would be an optimal seated posture. This posture does not allow for any activity. Task performance requires movement and tone.

This posture is simply a symmetrical posture. It may look nice, but it does not allow for control to occur. This posture only appears to be sound when thinking of the body as an anatomical “bag of bones.” However, the posture has little to do with any understanding of the neurophysiology of the body and how it must move and work to perform a task.

The 90/90/90 posture is problematic for other reasons. First, it is too restrictive. To maintain a person in this posture, especially one who has increased or varying tone, many straps are necessary to hold him or her in place. Using straps does not permit the body to learn how to move. Restriction only assists in preventing movement, or, paradoxically, because of the strapping, the body learns to “fight” the system, which adds more power directly at the point of the strapping. Second, if a person has low trunk tone and lateral and anterior trunk positioners and chest strap are added to surround the body, then the body will collapse into the straps. The larger and tighter the strap, the more the body may collapse.

How We Can Change Seating To Allow for Task Performance

First, seating for task performance does not involve a seated posture to maintain all day or for long periods. A task performance position is one that the person must be able to assume and maintain and in which the person can move. In short, seating has to allow a change in postures. The use of a tilt-in-space function can better support this, as can more adequate and less restrictive seating. We must not manage tone by stopping it and instead assist persons in controlling tone with task.

Starting with the head as the first extremity to control has worked well. Providing a task performance position with the seating and a tilt-in-space function can then allow a person to use a head switch for controlling power or a device. As the person works for short periods at the activity (less than 10 min), the seating can be observed and evaluated for its truly supportive value to that person. The person must be able to move but able to control the movement. The person learns this control through practice and through repeating an activity that he or she enjoys.

Most often with young children or with inexperienced adolescents or adults, I have found that controlling powered mobility with head access can provide an excellent foundation for all other access. With a powered system, one can change the seating without changing the seat with which the person is already extremely familiar. One can adjust the seating for the powered wheelchair for task performance; program the chair for head access; and then, while observing the person, make the necessary seating changes (while performing this task) that become obvious. For example, if the seat is too anterior,

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only tilted, then the person will lose trunk control. If the lower extremities kick out, show increased tone, or move into adduction, then the pelvis is not adequately stable. If the trunk collapses, then the anterior support is not enough. If the pelvis and trunk are full of extension and feet are pushing against the footplates, then temporarily remove them.

Work with the powered wheelchair for short periods within familiar places and with the task performance seating. As the person achieves success in mobility, the therapist can observe the body and the supports necessary. The task ends, and when the person repeats it, he or she can learn with the task how to use the body better.

Persons who use a wheelchair without the experience of weight bearing have great difficulty finding the task performance posture, which is why those of us who work with these persons must better understand how a body without adequate weight bearing works and provide systems that will allow weight bearing, pelvic stability, and mobility to occur. Thus, the person will be able to perform tasks and attain independence.

If you are interested in further discussion of this topic, please contact me. ■

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BuyerBeware.com

■ Daniel D. Lipka, MEd, OTR/L

Books, gifts, even cars. These are some of the items that people are buying on the Internet. Although the Internet does many things well, some products are not suitable for online purchasing. Seating and mobility systems are an area in which many professionals have particular concerns. More and more “e-commerce” sites offer manual or powered wheelchairs and various seating systems, and grave concern exists about the appropriateness of these sites.

For consumers who are experienced, know what they need, and have sufficient personal finances, the Internet may offer convenience that rivals purchasing from a local retail supplier. However, many professionals believe such clients as developing children, persons with new impairments, persons with more complicated needs, or consumers who are using a third-party funding source should avoid such purchases.

The seating and mobility industry is essentially unregulated. To date, rehabilitation technology suppliers (RTS) have only voluntary credentialing programs. The Rehabilitation Engineering and Assistive Technology Society of North America (RESNA) offers credentials for Assistive Technology Suppliers (ATSS) and Assistive Technology Practitioners (ATPs). The National Registry of Rehabilitation Technology Suppliers (NRRTS) awards a Certified Rehabilitation Technology Supplier (CRTS) credential. Unfortunately, these credentials are relatively new and are not widely recognized. Many home medical equipment companies have received accreditation from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), but their standards have little emphasis on more advanced rehabilitation technologies.

A qualified ATSS/ATP or CRTS is essential for assisting with the purchase of most rehabilitation technology equipment. During the past 10 to 15 years, major strides have allowed persons with severe disabilities to not only survive, but also thrive. As a result, the number of higher-technology seating and mobility systems has increased dramatically. These expanded options allow choices that lead to a better match between the consumer's needs and the equipment's features and benefits. However, with more choices, more opportunities for a mismatch occur, which can result in discomfort, decreased function, and even injury.

Unfortunately, many unscrupulous businesspersons place profit before independence or safety. A consumer with disabilities is likely not prepared to have a truck deliver a powered wheelchair with spe-

cialty controls or an adaptive seating system at the front door. This is, however, usually what happens when an Internet company is involved.

Internet sites cannot match the personal and professional services of a qualified local RTS. These services often include

- participation in a team evaluation that involves appropriate medical professionals,
- varied equipment choices and options,
- extended equipment trials,
- assistance with documentation and claims processing,
- assistance with setup and assembly,
- on-site adjustments and personalized modifications, and
- repair or warranty replacement after the sale.

The Internet may not be appropriate for purchases of seating and mobility technologies, but it is an excellent source for information. Many sites allow consumers and practitioners to seek specific information about disabilities, equipment specifications, user reviews and opinions, discussion groups, calendars of upcoming workshops and events, and many other helpful facts. As with any source of information, when using the Internet, one must consider the source. Similar to the risks inherent in purchasing seating and mobility equipment, information on the Internet can be equally unreliable. One must know the source of the information and compare that information with other sites and sources before accepting it as certainty.

Although major problems are associated with purchasing seating and mobility products on the Internet, an abundance of information exists to assist consumers and practitioners in making informed decisions (see Resources). Use the information wisely. Contact a qualified local RTS, and tell your clients to save their e-shopping for that new compact disc by their favorite artist. ■

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Resources

Organizations

RESNA: www.resna.org

NRRTS: www.nrrts.org

Information Sites

Abledata: www.abledata.com

National Rehabilitation Information Site: www.naric.com

Rehab Central: www.rehabcentral.com

Wheelchairnet: www.wheelchairnet.org

Manufacturers

In vacare/Pindot: www.invacare.com

Quickie/Jay: www.sunrisemedical.com

Permobil: www.permobil.se

Colours: www.coloursbypermobil.com

E&J: www.everestjennings.com

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