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Seeing, Judging And...Acting! Improving Health Perception and Meaningful Occupational Participation in Older Spanish Adults

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Abstract

Introduction. Occupational therapy programs have been developed in order to promote health in older adults. However, no published studies have yet been identified for the Spanish population.

Objectives and Methods. This study explores the benefits of an occupational therapy health promotion program called EnvejeHaciendo (*"AgeDoing"*). The study was conducted with 15 elderly Spanish adults, examining health perception and meaningful occupational participation using the Model of Human Occupation, as well as the pedagogical methodology "See, Judge, Act".

Results. The results showed an increase in the perception of health with reference to social functioning and the number of roles in which the participants wanted to get

involved in the future. The participants changed their own negative perception of elderly people, they adapted to the changes provoked by aging, and they got involved in meaningful activities such as physical exercise or social activities.

Conclusion. This program allowed participants to engage in meaningful occupations with other people and to increase perceived health status through raising awareness of difficulties.

Keywords: Elderly, Health promotion, Model of Human Occupation, Occupational engagement.

Introduction

Health promotion is the process of enabling people to increase control over, and to improve, their health. It moves beyond a focus on individual behaviour towards a wide range of social and environmental interventions (WHO, 1993). There are numerous studies concerned with the benefits brought about by health promotion programs in occupational therapy for the elderly. The primary objective of such programs has been to increase participation in a number of identified meaningful activities (activities with cultural, social and personal relevance) for life satisfaction, and to positively affect physical and mental health in people 60 years of age and older (Clark et al., 2011; Clark et al., 1997; Horowitz & Chang, 2004; Jackson, Carlson, Mandel, Zemke, & Clark, 1998; Matuska, Giles-Heinz, Flinn, Neighbor, & Bass-Haugen, 2003; Yamada, Kawamata, Kobayashi, Kielhofner, & Taylor, 2010) and adults (Barnes et al., 2008).These programs are expected to decrease possible future risks in independent people by adapting to the challenges of aging and eliminating the barriers or conditions that prevent or hinder the fulfilment of meaningful occupations. The contents included refer to essential areas of this vital age, such as safety, occupational balance, social relationships, finances, or cultural awareness. Some of the most marked effects of these programs are observed, for instance, in an improvement in the perception of health of the participants, vital satisfaction, the reduction of depressive symptoms (Clark, 2011), as well as in the quality (Clark, 1997) or frequency of relationships (Matuska, 2003). One of the programs that has gathered the most evidence in this regard is Lifestyle Redesign ® (Jackson, Carlson, Mandel, Zemke, & Clark, 1998), which, through the combination of individual and group interventions with elderly people, aims to provide education about the impact of daily occupations, promoting involvement in healthy and meaningful activities.

However, studies have yet to be conducted in Spain on the effectiveness of health promotion programs in occupational therapy in older adults. Although Jackson et al. (2009) have suggested ways in which the Lifestyle Redesign© program could be adapted to people from a range of ethnic groups, (including Hispanic people), these programs have traditionally been developed in North America or England. One fundamental challenge, however, for the design and implementation of an occupational therapy intervention is to consider the culture in which it is developed, and thus to learn the specific needs and realities faced by our clients (Iwama, 2007).

Based on an analysis of recent studies in Spain with samples of 154 retired people 60 years of age and older (mean= 74.3 years) from urban cities, and 216 participants from a rural context (mean= 73.6 years), it was found that the main activities of older people in Spain are basic and instrumental activities, with the remainder of their time being devoted to leisure (Triado, Villar, Solé, Celdrán, & Jose Osuna, 2009; Villar, Solé, & Osuna, 2006). With respect to leisure, the majority of the respondents reported that their main activity is watching TV, spending an average of 4 hours a day on this activity (Triado et al., 2009), and there appears to be a strong negative correlation between watching television and life satisfaction (Villar et al., 2006). These studies also reveal that, although this is the current situation of the elderly population in Spain, on a hypothetically ideal day, these people would prefer to devote less time to watching television and more to social issues and health maintenance (talking, walking together, travelling in company, etc). In particular, they have expressed the desire to spend more time in the presence of other similar people, whilst carrying out basic activities (particularly eating) that assume a more social and leisurely function that is quite distinct, from basic self-maintenance.

In almost all cultures and age groups, current social beliefs regarding aging are negative and are associated with diseases and the presence of disabilities (Chasteen, Schwarz, & Park, 2002; Hummert, 2003). This affects the image of the elderly person, who, despite not having these impairments, may experience them, and they become a self-fulfilling prophecy (Hummert, 2003). In Spain, negative perceptions of both health and social-motivational issues tend to increase with age, up to approximately 80 years (Sánchez Palacios, Trianes Torres, & Blanca Mena, 2009). Like younger people (mean=18.8 years), older adults (mean=70.6 years), believe that aging is a stage closely associated with disease and disability (Chasteen, Schwartz, & Park, 2002), in which it is difficult to maintain friendships or have sexual relations (Sánchez Palacios, Trianes Torres, & Blanca Mena, 2009).

Working with an elderly Spanish population, the purpose of the present study was to explore the benefits of a newly created health promotion program in occupational therapy, called EnvejeHaciendo (*AgeDoing*) in the areas of subjective health perception and occupational participation. This program aims to make the person aware of the relationship between occupation and health, and analyse their strengths and limitations when carrying out meaningful activities - both personal and social - in different spheres of life.

In order to achieve these objectives, we developed the present program based on a combination of two approaches. In accord with Yamada et al (2010), we used the Model of Human Occupation (MOHO) (Kielhofner, 2011) to raise awareness of the difficulties and opportunities to become involved in meaningful occupations. At the same time, we included a critical pedagogical approach derived from Paulo Freire (Gibson, 1999) in order to promote personal and social change.

Methods

Participants

The convenience sample was composed of 5 men and 10 women living autonomously in the community and who were regular users of the Centre for Active Participation in Zaidín, Granada (Spain). The initial criteria for inclusion in this study were the absence of degenerative dementia processes or unbalanced mental disorders, along with evidence of the ability to express and understand, as observed by occupational therapists.

All the participants gave their informed consent to participate in the research, as did the management of the Centre for Active Participation of Zaidín. The Department of Equality and Social Welfare in the Regional Government of Andalusia (including ethical standards) approved the program. The study was conducted in accordance with the ethical standards of the 1964 Declaration of Helsinki.

Research design and data collection

A mixed methods design was used, including quantitative and qualitative variables, which permits the use of methodological triangulation. In relation to the quantitative approach, data from two measurement tools about health perception and occupational participation were collected at the beginning and at the end of the program in a pre-test-post-test design. Regarding health perception, the SF-36 health survey was chosen (Ware, Kosinski, & Keller, 1994). Subjective health perception is an individual's relative level of wellness and illness, taking into account the presence of biological or physiological dysfunction, symptoms, and functional impairment. SF-36 is a person-reported survey of health that measures subjective health status through two different sections - physical and mental components - assessed by 36 items. It has a good internal

consistency (.80-.92) and it also showed an appropriate test-retest reliability (.60-.81) (Ware & Sherbourne, 1992; Ware, Kosinski, & Keller, 1994). The physical composite component (physical functioning, role-physical, bodily pain, and general health) and the mental component (vitality, social functioning, role-emotional and mental health) were also analysed (Alonso, Prieto, & Anto, 1995; Sullivan, Karlsson, & Ware, 1995; Ware, Kosinski, & Keller, 1994). Additionally, in order to assess occupational roles, Part I of the Role Checklist was used (Colon & Haertlein, 2002), which presents an adequate range of reliability in its original version (weighted kappa = .36-.57) (Oakley, Kielhofner, Barris, & Reichler, 1986) as well as an adequate inter-language correlation between the English and Spanish versions (r=.907). This part of the tool allows us to identify the person' s perception of their performance in internalized life roles in the past, present, and future (roles that he/she desires to have in the future).

In order to gain in-depth and subjective knowledge regarding changes in the perceived health and occupational participation that occurred when taking part in the program, an ethnographic approach was chosen as our research methodology, which allows for describing and interpreting what a group of people do within a given culture.

Two qualified researchers (one for each group) collected these qualitative data through participant observation techniques. The field notes were taken in accordance with an outline of the aspects to be observed (see Table 1). The researchers took the notes during the sessions, including textual words from participants. Some sessions were videotaped for further analysis.

---Please insert Table 1 about here ---

Procedure

Participants were informed of the program through an explanatory talk at the Centre for Active Participation in Zaidín. They voluntarily decided to take part in a program called EnvejeHaciendo (*AgeDoing*) in this centre. The 15 participants were randomly assigned to two working groups of 8 and 7 people respectively. Each working group was overseen by two professionals, one of whom was specifically tasked to conduct the session, and the other therapist to register, through participant observation, the comments and attitudes given by the participants. Participants who were unable to attend the workshop received explanations of the session through telephone calls or a visit to their homes.

The program was held twice weekly, with each session lasting for an hour and a half. The total duration of the program was 9 months (approximately 108 hours) spread across 40 sessions.

The EnvejeHaciendo *program*

The *EnvejeHaciendo* (*AgeDoing*) program was divided into thematic modules based on critical aspects for older adults, and collected from a panel of experts that comprised 6 occupational therapists specializing in interventions with older people (See Table 2).

The methodology used to carry out the program was based on the Model of Human Occupation (MOHO) (Kielhofner, 2011). Using this model, the purpose was to explain how occupation is encouraged, structured, and carried out in an individual´s environmental context. MOHO is a conceptual practice model based on open systems theory, by which people interact with the environment through the occupation. This model explains why people are motivated to do different occupations by describing the following concepts: interests, values and personal efficacy. In the same way, it explains

how the occupation is organized in patterns and routines which support the fulfillment of role responsibilities. Finally, MOHO analyzed the essential components to perform the activities: motor, process, social and communication skills. These three components interact with each other and the environment.

Similarly, the structure and methodology of this program was based on the pedagogy of the survey approach of Seeing, Judging and Acting (Gibson, 1999; Rodríguez, 2007). This methodology provides a logical structure to achieve the occupational self-analysis and the implementation of both individual and group actions. "Seeing" is the first stage and involves presenting the objective facts that are true for the participants in relation to the subject area to be covered. It is the stage that aims to analyse a common objective reality that is of particular concern for the group that is seeking transformation. From there, a common vision is built (i.e. a factual basis shared by the entire group). Subsequently, by "Judging", the group discovers the objective causes and consequences of the facts presented, on both a personal and social level. It is the stage at which each participant can contribute his or her subjectivity, and the group - as such - emits a common judgment on the topic at hand, according to their own values as opposed to those of the system in which we live. In addition, they are required to start imagining, without taking into account the physical, social, political, or economic circumstances in which the program is being developed. Following this, it is the time to plan actions to address and transform those realities during the "Acting" stage. Here, the group must deal with their ideal and with the current conditions in which they live, in order to develop an action plan. At this stage the participants freely assume their own proposed commitments, on both an individual and group level, with the aim of transforming the reality presented, if deemed appropriate.

These sessions help to clearly identify the problems, fears, or difficulties that prevent them from carrying out occupations that are of personal significance. In addition, these models allow the participants to determine the form, content, and all aspects related to the experiences brought about by these activities, resulting in greater control over managing their own lives. Table 2 shows the thematic modules of the program and the proposed exercises.

---Please insert Table 2 about here ---

Analysis of data

The quantitative data obtained from the SF-36 health survey and the list of roles before and after the program were analysed through a comparison of paired samples using the statistical software IBM SPSS Statistics 23 (IBM Corporation, 2011). Due to the size of the sample, the data obtained did not have a normal distribution, thus nonparametric statistics were used. For this analysis, the Wilcoxon's matched-pairs signed-ranks rest was employed.

The qualitative data was analysed using the software NVivo (version 9). All the field notes of participant observation were introduced in the program. In order to ensure reliability of the data, the first and last authors of this study read all the notes taken by the participating observers in order to form a general impression of the observations (research triangulation). Initial codes were assigned to the notes taken during the participant observation, and the codes were organized around similar topic areas. As more analyses were carried out, relevant topics were included in broader categories (Morse & Field, 1995). Subsequently, axial coding was employed where the rest of the data was compared to the topics and the resulting categories of previous

comparisons. Any disagreements regarding the coding were discussed amongst the researchers until a consensus was reached using the notes taken.

Results

The average age of the participants was 76.57 (range 60-87 years, *SD*=8.70). Eight of the participants were married (3 men and 5 women), 6 were widow(er)s (4 men and 2 women) along with a man who was separated but lived with a partner. All of the participants were educated only to a primary level. Two of them had difficulty with writing, but this was solved with help from their partners or the occupational therapist. The majority of them were born in rural contexts but they now live in the city. The economic level was low-medium for all the participants, receiving a pension between 600-800€ monthly. All of the participants had been workers up until their retirement. The women had worked as housekeepers, dressmakers, hairdressers and waitresses. All of the men had worked in the fields when they were in their villages, and then, in the city as mechanics, electricians, construction workers or bus drivers.

Quantitative data

Perception of health

The results of the SF-36 survey were compared before and after the program for all participants. First, the scores of the physical and mental components of the survey were compared (Rodríguez Vidal, Merino Escobar, & Castro Salas, 2009). Greater scores for both the physical (Pre: Mean=61.65, SD=25.58, Post: Mean=66.90, SD=26.71) and mental components (Pre: Mean=56.47, SD=28.75, Post: Mean=71.38, SD=29.37) were found, the latter reaching statistical significance (Z= -2.48; p <.05).

A more thorough analysis of the health dimensions provided by the survey revealed an increase in all of the dimensions after developing the program. In particular, statistically significant differences were obtained for social functioning (Z= -2.03; p <.05) and, to a marginal extent, for the dimension related to the occupational limitations due to emotional disturbances (Z= -1.71; p =.08).See Table 3.

---Please insert Table 3 about here ---

Occupational Roles

The average of the present roles increased slightly after the implementation of the program, though this failed to reach statistical significance (Pre=5.35; Post=5.57; Z= -.612; p=.54). However, a significant increase was found between the number of roles that participants would like to propose in the future before and after the completion of the program (Pre=4.71; Post=6.14; Z= -2.41; p <.05). In particular, (see Table 4) the roles that show a higher increase are those of friend and family member, followed by the role of home maintainer and volunteer.

---Please insert Table 4 about here ---

Qualitative Data

The qualitative data collected by participant observation and videotapes were structured into categories according to the different stages of the See-Judge-Act methodology. However, additional specific topics were identified by the researchers and were thus included in a logical diagram. Some literal words from participants (with fictional names) are described.

SEEING. Starting point. Perceptions of aging, current occupations and situations that make it difficult to carry out occupations

Change in the perception of the concept of aging throughout the program

Many of the participants from both groups believed that memory impairment and ailments were inherently associated with the aging process itself.

With respect to the occupations of the elderly, the participants said they had lost many of their previous responsibilities, but are now involved in a wider variety of activities. As one of the participants stated*: "Seniors should stay at an old people's home or babysit their grandchildren. To do otherwise is frowned upon."*(Elena)

It was, however, noted by the observers that as participants kept giving more specific examples and the program continued to develop, they began to reconsider the prejudices associated with older adults. For instance, as stated by Candela (one of the participants). *The problems each one of us has depend on each person. One can see things in other people who are not old."* Jose added, *"I feel better now than ever before, I have more experience."*

What occupations do the participants get involved in?

The participants primarily singled out two types of occupation. One of these was related to leisure and free time, most notablywatching TV. Vicente stated *"I spend long hours watching TV"*. In addition, they also reported regular involvement in fitness activities, such as gymnastic exercises or walking.

The other main occupation the participants described was related to productive activities such as cooking, cleaning and take care of grandchildren. *"I take care of household things, such as cleaning and cooking" (Cristina)*

The main occupations are primarily centred around their own family members.

"...I am waiting for my daughter´s holiday time to go and have lunch in Huetor (a village where they have a house) or for her to come and do some cleaning" (Cristina)

With respect to the subject of spirituality, some women in the group reported that they spend a few minutes at night praying - mainly for their families.

Present and actual difficulties experienced by the participants in the occupations they must and want to perform

Most of the participants expressed problems with cleaning the house as thoroughly as they had done throughout their lives, and also difficulties associated with physical endurance problems – with, for instance, climbing stairs or going shopping.

"After I fell and damaged my arm, I have a prosthesis, I am not able to do most of the jobs around the house, and my children have to help me". (Cristina)

"I get very tired going upstairs and I also struggle getting in the bath" (Vicente)

During the group work they repeatedly referred to memory or concentration problems, citing difficulties with remembering the reason for going to certain places within the house, keeping up with the workout sessions, memorizing songs or play scripts, and even knitting.

"It takes me some effort to follow the gym class, the teacher´s exercises, I can´t follow her..."(Miriam)

"I am knitting a jumper for my grandson, but I stopped because I don´t know how to carry on, I don´t know how to finish it" (Claudia)

The issue of falls was rather disturbing for the group. All members of the group reported at least one fall, which might have happened at home or in the street. The group was able to identify the causes of these falls as stemming from an unsafe environment, the loss of certain skills, or a lack of attention.

"Here in Zadin (the name of the area) the pavements are uneven and that is dangerous" (Jose)

"...we need to be careful, sometimes you take a drug and you get dizzy" (Claudia)

JUDGING. The ideal occupations

What occupations would the participants like to engage in?

At this stage of the program, the participants were encouraged to discuss the activities they would like to do, without thinking about or limiting themselves to the actual conditions in which they live.

Regarding responsibility, the participants expressed their desire to advise or help sick people, those with insufficient resources, or people with depression.

"I would like to help ill people with nervous problems or depression" (Elena)

"If I had money, I would love to help you, but my pension is very short" (Aurora)

The family is clearly of central importance in the lives of the participants. According to the notes taken by the observers, many of the participants expressed their desire to spend more time with their families and engage in different activities with them.

"I have a very good relationship with my husband, but I would like to spend more time with him. For instance, I used to go alone to church, but now he comes with me, and on Sundays I am the happiest person in the world" (Elena)

ACTING. Ready for action

What activities did the participants commit themselves to?

Both initially, and as a result of changes in the perception of the **concept of aging**, both groups carried out dissemination activities to combat stereotypes. One group drafted a press release, while the other group participated in a radio program that included a story where they valued the features of this stage of their life cycle.

They say I have memory loss, I would invite you to try my cooking, especially "salmorejo", and you´ll be shocked. (Fragments of the press release)

In the module concerned with **occupational balance**, the participants expressed their commitment to watching less television in order to engage in leisure and free time activities that are more in line with their interests (handicrafts, reading, doing repairs or singing in a choir or learning activities).

"Instead of watching TV, I am going to do some handicraft in the afternoons I am free, Mondays and Wednesdays; and I am going to make alphabet soup" (Carmina)

"I am going to join the time bank and the guitar classes. I am going to join on Monday. I always liked playing guitar." (Jose)

Another of the aspects the observers highlighted was the participants' statement to **keep healthy**, which led them to commit themselves to walking more often or doing physical exercise in different modalities.

(Gymnastics) "I am going to try going to the sports centre with Juan and to the civic centre on Tuesdays with Salvador, and see which I like more of the two". (Vicente)

"My legs don´t let me do much, but I am going to go walking on my own" (Mónica)

Within the module of **strategies of adaptation to aging**, the participants made some changes to the activities that require a greater cardiorespiratory or muscular capacity,

such as thoroughly cleaning or walking to the supermarket. Some of them suggested using calendars, diaries, or notebooks to record tasks to be completed. In addition, they wanted to learn the use of mobile telephones in order to talk to relatives.

"I am going to start to write the doctors dates in the calendar so I don´t forget them"(Vicente)

In this regard, peer support encouraged one participant to help another who stated she had forgotten how to knit (which was a very significant activity for her).

"I am meeting Claudia before the handicraft class so I can help her to finish off her jumper knitting project"(Candela)

Given that falls are a recurring fear, the participants decided to produce a guide containing recommendations on how to avoid falls. In addition, they committed to making changes and paying more attention while performing their activities so as to avoid risks.

"I am going to carry a panic button while I am in the house, always on me, I only put it on the toilet when I´m going to shower" (Carmina)

In terms of the subject of **social relations**, the groups set specific commitments to engage in activities of interest with relatives or friends who, in some cases, they had not seen for a long time. Some participants also pledged to meet with other participants in the group.

"If you want we can go to have dinner at my place some night, before the cold season comes". (Julián)

"I am going to see a cousin that is in Alfacar (a village in Granada), it has been a long time since I saw him. I am going to ask him to go for a walk around". (Vicente)

Miriam, Carmina and Elena were interested in exploring options for **volunteer** activities, as stated by Miriam: *"I am going to go to church with Candela to visit ill people, although I need care too"*. In the end, rather than directly attending to people with needs, the actions they committed to were linked to attending mass and praying for them.

Discussion

This study explored the benefits of an occupational therapy health promotion program aimed at senior citizens in Spain, applying the MOHO and the educational methodology of Seeing, Judging, Acting.

Regarding the participants perception of their own health, it is clear that the program led to participants achieving significantly higher scores on the mental component, specifically in terms of the social functioning component of the SF-36 survey, through which they extended their social activities without interference from physical or emotional problems. These data also support the results obtained by the study with the Lifestyle Redesign© program, where all the dimensions of the SF-36 health survey increased significantly (Clark et al., 2011). The lack of significant differences in terms of the other dimensions may be due to a problem of statistical power, given that the number of participants is low.

In relation to occupational participation, our intervention was effective in extending the number of roles that participants wished to assume in the future, as assessed by the Role Checklist, which shows that the program helped to increase their future occupational expectations. The maintenance of occupational roles in elderly people should be a very important target intervention because it is strongly correlated with life satisfaction. (McKenna, Broome, & Liddle, 2007). Roles that were more sensitive to this increase

were those of friend and family member. These data are in line with the results obtained from the social functioning of the SF-36 survey, as well as the results of the study by Matuska et al. (2003). Therefore, the program appears to yield positive results, particularly in the social dimension of the participants. The increases observed in the future but not in the present roles may be due to the fact that the concept of role requires that it be performed in relation to others, meeting a series of expected behaviours and incorporating role-specific activities into the personal routine (Kielhofner, 2011).

Qualitative data showed that the group of participants in this study had some prejudices at the beginning about aging, associating this time of life with the loss of skills. However, with these participants it was possible to achieve a change in the ideas about elderly people, as shown in other studies with older adults in University programs (Fernández-Ballesteros et al., 2013) or nursery students as participants (Cobo & Pfeiffer, 2015). The program also allowed the participants to adapt to both their current limitations and those that may possibly emerge in the near future. In the occupational balance modules, the participants made choices regarding meaningful activities according to their interests and values. They designed and implemented certain individual or group activities that brought cohesion to the group and significance to their personal lives. Offering people space for reflexion about their participation in meaningful activities is crucial in the change process, given that it has been shown that getting involved in these types of activities is closely related to vital satisfaction, as well as to the individual perception of health status (Eakman, Carlson, & Clark, 2010). Amongst these meaningful activities, the participants were particularly interested in physical activities and sports, which not only has the benefit of being aware and able to make choices according to their own interests and values, but is also beneficial for muscles, bones, and the cognitive state of these type of people (Moayyeri, 2008, Liu-

Ambrose & Donaldson, 2009). Similarly, participating in social activities after the program, both with people within their group or relatives and friends, has been one of the main benefits of this enterprise.

It is worth noting that carrying out actions in the community was rather difficult to address. Although the participants considered it important to help people in need, few actions and few people became involved in occupational roles directed towards these people outside of their family context. Nevertheless, as pointed out by some studies, this issue is important for some people, and carrying it out results in improved health (Mountain & Craig, 2011) in satisfaction (Celdrán & Villar, 2007) or to increase self-esteem (Principi, Schippers, Naegele, Rosa, & Lamura, 2016). Future research must explore in more detail how to become involved in activities aimed at other people, when the value of helping others is present.

Implications for practice

Finally, it is worth highlighting that the proposed methodology, through the Seeing, Judging, Acting program, allowed us to present and address several issues that the group of experts highlighted as important. This methodology allowed for delving deeper into aspects that would not have otherwise emerged in an open assessment due to fear, taboo, or stereotyped responses. In this way, the participants were able to take action whenever they wanted to and react to problems or situations in which they felt interventions to be necessary. In addition, the use of MOHO allowed us to implement a conscious, analytic, and active change.

Limitations and future recommendations

One of the limitations of this study was the fact that it was both small, and a convenience sample. Caution should be taken to generalize these findings to diverse

groups including people that differ in terms of disability, sexual orientation, religious affiliation. However, given the scope, the time, and the data collected, it can serve as a starting point from which we could continue to develop further studies, in different cultural contexts.

Conclusion

The Envejehaciendo (Agedoing) program, through a combination of the See-Judge-Act approach and MOHO, succeeded in improving health perception and meaningful occupational participation in Spanish elderly participants, particularly in the social dimension. These person-centred methodologies triggered occupational changes according to values, beliefs, or participant interests, through detecting and eliminating barriers.

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Table 1. Outline for the aspects of observation

Participant Observation Template
Dynamics and relationships among participants.
Participant opinions and perceptions regarding the subject matter.
Participant emotions
Participant commitments to change.

Table 2. Description of the different modules of the program and the given dynamics

Module 1. Relationship between occupation, health, and aging	Module 2. Occupational balance
• Defining in groups health, occupation and aging using theatrical exercises where the participants have to play a role to define the concepts. • Building the timeline of life, linking life stages, occupations and health perception. Constructing the occupational history of the participants (Based of the OPHI-II questionnaire).	SEE • Complete a table of frequencies of activities. Build a graphic with the distribution of the activities according to occupational tasks. JUDGE • Discovering exercises about the factors that allow or hinder (using MOHO) involvement in significant occupations. • Debating in groups and individually the degree of enjoyment of significant occupations and the maintenance of an occupational balance. ACT • Planning changes and proposing individual and/or group commitments.
Module 3. The role of senior citizens in society	**Module 4. Adaptation strategies in relation to the changes brought about by old age**
SEE • Analysis of the image of elderly people in media advertising and news. Group debate. • Participants fill in questionnaire about negative stereotypes towards elderly people (CENVE) JUDGE • Debating the existence of negative stereotypes and the need (or not) to change the image of elderly people in society. • Dynamic to explore the causes and consequences of the society maintaining a certain image of elderly people. ACT • Plan of action to combat stereotypes (in cases where these exist)	SEE • Analysis of the types of limitations that stop or could stop participation in different occupational tasks. JUDGE • Debate the concept of adaptation. • Describing the need to adapting or not. • Watching documentaries of elderly people with severe motor limitations that have adapted to participate in occupational activities. ACT • Planning changes and individual and/or group commitments to allow the adaptation.
Module 5. Social relations	**Module 6. Knowledge and capacity for action of older adults to build a more supportive world**
SEE • Developing a social relationships map (concerning both current and past relationships). Describe different types of social relations and their meaning for each participant. JUDGE • Dynamic to explore the causes and consequences of having (or not) good social	SEE • Reading different people´s occupational lives around the world. • Analysis of occupational apartheid situations. JUDGE • Elaborate a common definition of responsibility. Watch a short film about responsibility. • Thinking about the causes and consequences of the occupational apartheid.

relationships. • Exploring the need for social relationships. ACT • Planning changes and proposing individual and group commitments. • Planning actions to re-take or make new social relationships.	• Rating the need of acting to certain situations. • Watching organisations acts on elderly people that fight rights causes (Iaio Flautas) ACT • Describing individual and/or group commitments
Module 7. Finances	**Module 8. Pharmacology**
SEE • Exercise about income and expenses • Exercise to explore the participant´s needs JUDGE • Rate the grade of importance of the concepts described on the table • Thinking about the financial difficulties to get involved in significant activities. ACT • Planning individual and group commitments.	SEE • Complete the table about drugs that the participants take. • Questions about whether or not they know the risks of making mistakes while taking drugs. • Questions about their knowledge of natural medicine. JUDGE • Thinking about the causes and consequences of the amount of drugs they take and the bad use of medicine. ACT • Planning changes and individual and/or group commitments.
Module 9. Spirituality and end of life	**Final Session**
SEE • Dynamic to know participant´s perspective about death. • Dynamic to explore the activities they do to explore their spirituality. JUDGE • Watching a film about closing a cycle (“My life without me” Film) • Dynamic exploring they way they would like to die and what spiritual activities they would like getting involved with. ACT • Planning of changes and developing final individual and group commitments.	• Giving final commitments • Closing party

Table 3. PRE and POST means (and Standard Deviations) for the various dimensions of the SF-36 survey.

	PRE	**POST**	Z	*p*-value
Physical functioning	60.75(26.87)	68.93 (26.76)	-1.41	.16
Occupational limitations due to physical pain	62.50 (43.57)	66.07 (45.58)	-.42	.67
Occupational limitations due to emotional disturbances	42.86 (46.09)	69.05 (44.27)	-1.71	.08
Energy/Fatigue	57.14 (30.43)	60.36 (31.95)	-.55	.58
Emotional wellness	57.14 (25.80)	67.71 (29.75)	-1.3	.19
Social functioning	**68.75 (25.83)**	**88.39 (21.63)**	**-2.27**	**.02***
Pain	66.79 (26.25)	71.61 (24.45)	-.89	.37
General health	56.16 (22.11)	60.99 (21.21)	-1.02	.31

*$p < .05$

Table 4. Number of participants that marked each role (present and future) before and after the program.

	PRESENT roles		FUTURE roles	
	PRE	POST	PRE	POST
Student	6	7	6	7
Worker	1	0	0	0
Volunteer	5	5	4	7
Caregiver	7	5	4	5
Home Maintainer	13	14	10	13
Friend	7	12	6	13
Family member	11	14	10	14
Partner	7	7	7	8
Hobbyist/Amateur	13	11	13	13
Participant in organizations	5	4	5	6