(UPBEAT MUSIC)

SPEAKER:  
You are listening to Everyday Evidence presented by the American Occupational Therapy Association, helping the occupational therapy practitioner apply evidence to practice. He's your host, Matt Brandenburg.

MATT BRANDENBURG:  
OK. Today, we are joined by Dr. Mary Hildebrand and Dr. Amanda Mack. Mary is an associate professor and the Founding Director of the Tabor-Connor Family Occupational Therapy Center for Learning, Participation, and Rehabilitation at the MGH Institute of Health Professions. Mandy is the current director and an assistant professor of Occupational Therapy and soon to be the Director of Post-Professional Education at Washington University in St. Louis. I'm excited to speak with you both about the systematic review on stroke for caregivers of people with stroke you've contributed to in conjunction with AOTA's EBP program. Thank you so much for being on the show today.

DR AMANDA MACK:  
Thanks for having us, Matt.

DR MARY HILDEBRAND:  
Yeah, happy to be here.

MATT BRANDENBURG:  
It really is our pleasure. Before we jump in the specifics of the systematic review, could you share with us what motivates you to conduct and synthesize research and evidence related to people with stroke and their caregivers?

DR MARY HILDEBRAND:  
I guess I'll go first. This is Mary. I was a caregiver for seven years of my husband who didn't have a stroke, but he had ALS. And I was so glad that I was an occupational therapist and I knew a lot, but it was still hard. And I think that of those people that who have no medical background, they are really struggling to help their family member. And I've written a couple of chapters for two editions of Glen Gillen's Stroke Rehabilitation text about caregivers of people who have had stroke. And I found out that about 74% of people who have had a stroke are cared for by family members or friends. So, that's a lot of people.

DR AMANDA MACK:  
And my passion for the topic isn't as personal as Mary's, but my clinical practice was in long-term acute care. And I felt as a clinician that I just wasn't preparing caregivers well, that they were going home and having to figure things out on their own, that the limited training and education as providing them just didn't feel adequate. And so, as I moved into doing some research, this topic really felt important to me.

MATT BRANDENBURG:  
Absolutely. It's interesting that you both have different backgrounds in observing caregiver burden. As a caregiver and as a practitioner, I think it is something that a lot of OTs are aware of. How would you describe the unique experience of caregivers for people with stroke?

DR MARY HILDEBRAND:  
Well, stroke is one of the most common conditions that may require caregiving. And it affects not only the person's physical capabilities, but they may have mental health impairments, there may be cognitive effects from the stroke. And I'm really interested in the topic of aphasia that occurs in about a third or anywhere from 20% to 40% of people who have had a stroke. And that's a really particularly difficult condition to deal with when you're a caregiver. One other thing I'd add is that caregivers of people who have had a stroke are really concerned that their loved one not have another stroke, so that adds this layer of anxiety, both for the person who's had a stroke and for their families.

MATT BRANDENBURG:  
There are so many changes that happen in the life of someone who has experienced a stroke and for their caregiver. So, thank you for highlighting some of those experiences that people might be going through. Why would you say it's important for practitioners working with this population to consult and use systematic reviews to guide their clinical reasoning and their intervention planning?

DR AMANDA MACK:  
I think that it's important for all practitioners to be consulting and using systematic reviews as much as they can. Systematic reviews really give practitioners an overview of the literature. Mary and I spent many, many hours looking through it and analyzing and really finding what does it say as a whole. And that really is an important summary for practitioners to be able to know. And we know that using evidence to guide our interventions and to guide our clinical reasoning, it makes it more effective. It makes it worth our time when we're doing these interventions. And of course, it's important as we work towards getting reimbursed as well to show that what we're doing actually works.

DR MARY HILDEBRAND:  
I completely agree. I think the key word there that Mandy said is that summary, it summarizes. We did this broad look and we kind of synthesized it down and summarized what has been shown to work.

DR AMANDA MACK:  
And I think that it's also, at least my experience in working with clinicians and practitioners as an educator, that most people aren't using any evidence at this point for how they're educating caregivers and really thinking about the best way to do that. So, having any type of evidence, but especially this high quality evidence to guide those efforts is a really important step towards being an evidence-based practitioner.

MATT BRANDENBURG:  
That's a really interesting point. I think sometimes it can feel natural when you're kind of on the spot. A caregiver might ask a practitioner for recommendations or what to do and to just say the first thing that comes to mind and give them recommendations that a typical OT practitioner would do if they were being a caregiver. Being able to have a high level of evidence, like you mentioned, to draw from and really make sure we're giving evidence backed recommendations is so impactful. And I'm always extremely grateful for people who contribute and do these systematic reviews because it makes that process so much easier for the practitioner. Instead of having to dive through and sort through so much literature, it's all right there in the systematic review.

DR AMANDA MACK:  
Yeah, I mean, we know practitioners have about zero extra minutes every day to be sorting through articles, so having something like a systematic review to quickly look at, there's even shorter versions, systematic review briefs, to really give you the information really quickly. It's a really valuable tool.

MATT BRANDENBURG:  
What was the focused question that you used for this systematic review?

DR MARY HILDEBRAND:  
Here it is. What is the evidence for the effectiveness of interventions within the scope of occupational therapy practice for caregivers of people with stroke to facilitate maintaining their participation in the caregiver role? Quite a mouthful.

MATT BRANDENBURG:  
That is quite a mouthful. What can you tell us about that question? Why did you choose to encompass those specific factors into the review?

DR AMANDA MACK:  
One of the things I love about this question, despite it being really long and complicated, is that it focuses on participation, which is the hallmark of OT. So, it's talking about what can we do to help the caregiver participate in a role, really not focusing on injuries or looking at outcomes of the person they're caring for, but really focusing on the caregiver themselves and their participation.

DR MARY HILDEBRAND:  
Yeah. I love that, Mandy. Also, I think it's important to note that it says within the scope of occupational therapy practice, so some of these randomized control trials that we looked at were not carried out by occupational therapists. But we could have delivered these interventions, so we had to make sure that the intervention that we looked at in these research articles was within our scope of practice.

DR AMANDA MACK:  
That's a good point, Mary, because there's actually very little literature about OTs carrying out these interventions, like you mentioned. So, expanding it within our scope was an important part of this question.

MATT BRANDENBURG:  
And that's an interesting point. I'll be interested later on in this interview to hear what OTs can do in general to contribute to more research being done in relation to this topic. But as far as your steps after developing this question, how much research, how many articles were you able to find in the current literature related to it?

DR MARY HILDEBRAND:  
We had a lot. The AOTA team has a medical librarian and a methodologist, and they looked through all these databases with these key terms around caregiving and stroke, et cetera, and they identified about 4,000 articles. Well, no worries, we didn't have to go through those. And then finally, they sent us, I think around 550 abstracts, so Mandy and I and some graduate students that we had, screened those abstracts and excluded those that didn't meet the criteria of being within our scope of practice for adults who've had a stroke, et cetera. And then we screened full texts of articles and we finally came down to 33 articles that fully met our inclusion criteria.

MATT BRANDENBURG:  
Wonderful. I love hearing descriptions of this process. I know from a practitioner's perspective, it's intimidating enough to try and conduct your own research to help guide intervention planning, but then hearing how there's 5,000 articles related to the topic, and it's just very gratifying to know that people go through that process to narrow it down to 33 focused articles with good high levels of evidence to help practitioners.

DR MARY HILDEBRAND:  
I think we were lucky, weren't we Mandy? That for this particular topic in stroke, that we had more articles than many of the AOTA EBP folks do, and we were able to just exclude anything that wasn't a really high level of research. Right, Mandy?

DR AMANDA MACK:  
Yeah. And it just can improve our confidence in our outcomes when we're using those really high levels of evidence.

DR MARY HILDEBRAND:  
Yeah.

MATT BRANDENBURG:  
Absolutely. And what did these 33 papers that we came to, what were some of the most common OT interventions for caregivers of people with stroke that were found in this review?

DR MARY HILDEBRAND:  
When you ask about what are the most common OT interventions for caregivers; well, what we found might not have been the most common. OK? We found this article for our background, for our lit review. There was a survey of OTs, PTs, and SLPs and what they did with caregivers of people with stroke. And everybody provided education and training to the caregivers. But very few of them provided support, stress management, referrals to support groups, even things like financial management, which is so important for caregivers. Everybody did the education and training in an inpatient setting, and there was an estimate that in total, they provided 45 to 60 minutes of intervention with the stroke caregiver. So, education and training, yes, but just a few minutes. So that's what's the most common out there, and then what we found was different about what worked.

DR AMANDA MACK:  
I think when you reflect on what's most common, this education and training, maybe up to an hour. You can just think as a practitioner how many things you can't get to in that amount of time and how limited that is. I think our results really show the gaps in practice when we really look at what is best practice versus what's happening most often.

MATT BRANDENBURG:  
Absolutely, and you've mentioned already in the formulation of this question how important caregiver participation and wellbeing are. Those are two areas of occupational performance that are tough to address with education. Is there anything else you'd like to say to what makes addressing caregiver participation and wellbeing so important and necessary for practitioners to do?

DR MARY HILDEBRAND:  
Yeah. I am particularly passionate about why we need to do this. I mean, the practice framework, of course, talks about the caregiver being our client as well. But in the literature, you find that there are positive effects of caregiving on the caregiver, but the literature primarily finds that there are a lot of negative effects on the caregiver like physical injuries and the physical effects of stress, and the lack of sleep, and the lack of socialization. Then, of course, there are the mental health problems associated with caregiving like depression and anxiety. The literature talks about caregiver burden or caregiver strain, and that's a very subjective component for every caregiver. Then, you find that there are so many financial problems. You can't work, so there's the cost of being unable to work or missing out on promotions, the cost of hiring an aid, the cost of equipment, et cetera. There are just so many things that we might be able to address to help the caregiver. Also, research shows that the better off the caregiver is, the better off the person who's had a stroke is.

Their quality of life is better. They have fewer hospitalizations. They're less likely to be placed in a long-term care facility. So there are a lot of really important reasons to address caregiver participation and wellbeing.

DR AMANDA MACK:  
My interest is largely in health promotion and wellness. Being a caregiver puts those persons at such high risk for negative outcomes like Mary was talking about, but also, their own medical issues, so cardiac issues, having their own stroke, ignoring their own underlying conditions and their own health and wellbeing. Then, you can end up with two people who've had strokes or a person who's had a stroke in another condition, and it just can snowball. So my interest is also in, "How do we keep these people well? How can we establish habits and routines, and give them resources to be able to take care of themselves while they're helping take care of someone else?"

MATT BRANDENBURG:  
That really is a million-dollar question, and I want to ask, what did the systematic review find or suggest that our interventions for caregivers which are supported by evidence that practitioners could use?

DR MARY HILDEBRAND:  
Mandy and I came up with five different themes of types of interventions, and they were cognitive behavioral therapy techniques, then caregiver education only, caregiver support only, and then a combination of caregiver education and support, and then multimodal interventions. So everything, but the kitchen sink is thrown in on those multimodal interventions. For example, cognitive behavioral therapy techniques. We found that the studies or the research interventions that showed some of the strongest evidence is using problem-solving therapy along with education. So problem-solving is a cognitive behavioral therapy technique or method whereby you teach the caregiver how to manage their stress, you teach them how to identify problems, how to generate solutions, and then implement those so solutions. It's like a coping strategy, and it helps them to build their self-efficacy. I almost think of problem-solving is very similar to co-op, and I know the cognitive orientation to daily occupational performance.

I think co-op is a problem-solving technique. So we found that that was supported by really strong evidence.

DR AMANDA MACK:  
We also found a smattering of other things that were shown to have strong evidence. So one of the main things was that education and training was delivered after discharge from acute care. So any education and training that was delivered just in the acute care setting didn't have a lot of evidence to support it. So giving training and education over time or after discharge was actually found to be a better intervention. We also found that education and support alone may not be sufficient, that using this multimodal approach, right, using multiple ways of delivering information, training, education support, was more effective than just going at it from one way. And we know that as OTs, that people learn differently and at different times in different places. And we also found that delivering interventions at home was really effective. So versus delivering in a clinic or delivering an inpatient, delivering those interventions in the home was much more meaningful and I think aligns nicely with some of those problem solving techniques that we've been talking about. I think the final thing that this found that was really key was that it needed to be individualized as well.

So curriculum that was delivered just to a group that wasn't tailored to those people wasn't really effective from this systematic review that it really needed to be individualized to each caregiver and what they were going through and experiencing.

MATT BRANDENBURG:  
Absolutely. Thank you for summarizing these five themes. I do have some follow up questions. I'm a pediatric practitioner, so don't have much experience in working with adults who have experienced stroke or caregivers of people who have had stroke. What are kind of some main tenets of the education and support themes that you discovered? What should practitioners be including in their education and what does the support theme and intervention really look like?

DR AMANDA MACK:  
Such a great question, Matt, and I don't know that I have the answer from this systematic review. So one of the challenges that we faced with this was that most of the interventions did multiple things and they all did them differently. And so it was really difficult to boil it down to what's actually causing the change, right? What's actually making a difference? So those essential ingredients were really hard to pinpoint. What we know is more about, rather than what content is in it, we know that one-on-one training's better than group. We found that delivering education over time was more effective than a condensed version. So we're talking weeks and months, not days. We learned that in person isn't always the best. That sometimes especially support and follow up trainings for things can be delivered mostly via phone, but I'm sure via video call, all those types of things, and that that can be really effective as well. So I don't know that I have a best practice for what is delivered, but I think that individualized piece in using our occupational therapy lens to think about what those clinicians might benefit from is a good place to start.

DR MARY HILDEBRAND:  
There's so many things that you have to address and it really depends on the person who's had the stroke, what their needs are, and the person who is doing the caregiving. You might be doing feeding training, you might be doing transfer training. How do you speak with a person with aphasia? Yeah. There are just so many different things that you're going to be doing, educating the caregiver on. And it's really individual. So that's why it's so important to do that problem solving training because problems are gonna change over time and you've got to give them the tools to examine the problems, come up with different strategies and try those out, see what works, and give them the confidence or the self-efficacy that they can address those problems. 'Cause they can be they wide-ranging with a stroke.

DR AMANDA MACK:  
Yeah, it makes me think about the whole, teach a man to fish, type of thing and how we can never address everything that's going to come up and every person is different. So rather than trying to find the secret sauce of what we should be teaching, it's OK, we need to think about how to equip them to manage these things.

MATT BRANDENBURG:  
I love that. I love that metaphor. Sounds like training caregivers to become OTs in a way and really gain these skills and tenets of client-centered practice. And it sounds like a one-on-one format with kind of more of a distributed practice, as opposed to trying to cram before an exam, if I'm relating this to our experience in OT school, really leads to better outcomes for caregivers. We'll get back to our interview right after this quick word. We try to make research more applicable and more consumable for our listeners, and completing the survey that we mentioned on each episode helps us to do just that. AOTA members are now eligible to receive one contact hour for listening to an episode of our show and completing the survey. The survey is still only three questions long and can be found by following the link in this episode's description. Get yourself a contact hour and help us to improve the show, improve the resources AOTA provides to its clinicians and improve the application of evidence to practice in our field. Now back to the interview.

Awesome. Was there anything else you wanted to touch on for common delivery formats or lengths of time that are most effective in assisting caregivers to maintain participation?

DR MARY HILDEBRAND:  
The research used everything they used, they used one-on-one. They used groups. They used pre-discharge, post-discharge, they did things by telephone, by video call. They did at-home visits. There was one session versus many sessions over months. There were a lot of different interventions, a lot of different settings, methods of delivery. We just found the gamut of things.

DR AMANDA MACK:  
There definitely wasn't a consistent length of time of the intervention or even the mode of delivery, the in-person, if it was telephone calls or anything like that. I do think it is important to note that in-person isn't always the best, and especially in the world we're living in of telehealth, considering alternative ways to do training is important.

DR MARY HILDEBRAND:  
In person is great. It's lovely, but sometimes when you're caregiving you can't get in. You may have to hire someone to stay with a person who's had a stroke or you may have to bring them with you or sometimes it's just really difficult to make that trip in. So sometimes that telephone call or video call or telehealth is actually better.

DR AMANDA MACK:  
It makes sense when you think about it, right, Mary? That for those reasons you just said that those remote options are good options for caregivers sometimes, but also then the in-home visits are good options. Because it helps eliminate some of those barriers for caregivers that we wouldn't necessarily think about.

MATT BRANDENBURG:  
Absolutely. It's all going to depend on the individual and really trying to provide that personalized care and support. Are there any interventions that you would say practitioners might want to avoid or only use with caution when working with this population?

DR AMANDA MACK:  
I think the biggest things to avoid are trainings that are not individualized and that happen prior to discharge in a very short amount of time. So basically the opposite of everything that we just talked about. Giving too much information at once that may not be relevant, not equipping them to problem solve on their own. I think actually it's probably a lot of how we do our training now, but important to think about that the evidence really doesn't back those approaches.

MATT BRANDENBURG:  
Absolutely. Thank you. Before I move on to some application questions, I wanted to ask if either of you had additional resources you would recommend to listeners who maybe want to learn more about problem solving therapy or any of those five themes?

DR MARY HILDEBRAND:  
When we get our training in occupational therapy, we are one of the few rehab disciplines who have mental health courses. I would refer us back to our mental health course to look at cognitive behavioral therapy, particularly problem solving techniques. That's the main resource that I can think of.

DR AMANDA MACK:  
I think that for practitioners who really are delivering education and training and support to caregivers, I don't know that I have a specific resource, but really encouraging practitioners to think about learning about problem solving therapy or CBT as some of their continuing education and really pursuing that because the caregiver is also our client, not just the person with the stroke. So really thinking about expanding our skills and purposefully doing that rather than relying on what we've learned in school however many years ago, or what our colleagues are doing, but really thinking about how can I advance my own practice in these areas that we know work.

MATT BRANDENBURG:  
Absolutely. I love that. Thank you for those recommendations. How would you recommend a practitioner determine which evidence supported intervention is or are appropriate to use with their clients and caregivers?

DR MARY HILDEBRAND:  
I think something we haven't mentioned yet is doing a thorough assessment of the caregiver to determine their needs. There are many, many assessments for caregivers. A website, I think it's called Family Caregiver Alliance, has lists of caregiver assessments. The Family Caregiver Alliance has a very comprehensive list of assessments for caregivers from their physical capabilities to their knowledge about how to provide care to the potential resources that they might use. There are lots of caregiving assessments out there.

DR AMANDA MACK:  
And I think also for practitioners who are worried about reimbursement or limited time, you can also just start small and incorporate a brief occupational profile of the caregiver even. I'm a little bit embarrassed to say that I think the furthest I used to get into these conversations was, "Are you able to help? Tell me about your home. Do you work?" Very, very basic questions without really getting into, "OK, what are we really dealing with here? How can we best support you?" So just taking the time to again, frame the caregiver as a client. We often think about the caregiver as a team member, which is true, but really thinking about these people can also benefit from OT intervention and thinking about how can I expand what my definition of the client here is.

MATT BRANDENBURG:  
Absolutely, and that's a great point, Mandy. I think that's a common feeling for a lot of practitioners, is that there are these other pressures of productivity and still having a personal life and getting things done that sometimes it can be tough to view a caregiver with the same amount of care and detail as a client on a caseload. How would you recommend a practitioner really design and implement a client-centered and an effective intervention for a caregiver after this step of using an occupational profile and using an assessment like you recommended Mary?

DR MARY HILDEBRAND:  
That's the first step, is doing that thorough assessment so that we can plan an intervention.

DR AMANDA MACK:  
After we do an assessment, we have the information, I think it requires a shift in mind and probably a shift in practice, and this is, I'm sure particularly hard in COVID but thinking about how can we have the caregiver there more than just that 60 minutes that we're doing transfer training? How can we have them there, helping practice problem solving throughout rehabilitation or the inpatient stay? Or if we're doing home therapy, can we ask that the caregivers there involved that we're not as hands-on as OTs, that we are a coach in that place and you're still working on bathing and dressing and building endurance and cooking meals, all these things? But how can we empower the caregiver in our sessions to practice problem solving? How can we help them drive the sessions and learn alongside the patient? How can we really take a more team approach to this? I think too often, we think we need to train the person and then the caregiver is an afterthought, but really involving them every step of the way.

And that can also really help with reimbursement challenges. When you're working on showering and ADLs, you are going to get reimbursed whether the caregiver is there or not, so might as well bring the caregiver along.

DR MARY HILDEBRAND:  
Right. And you're assessing the caregiver and their abilities and their capabilities in addition to doing that problem solving training. Yeah, that's right, Mandy.

MATT BRANDENBURG:  
I love that. Those are wonderful recommendations, and it really sounds like this shift in perspective and approach is what leads to the best outcomes for the person who experienced the stroke and for the caregiver. Could you share a case study or a personal experience that you've had when you saw or implemented a caregiver intervention that led to a positive outcome?

DR AMANDA MACK:  
Mary and I had a hard time with this question because I don't think either one of us have a super great success story, and I think that's partly why this research is so important, because what we see in day-to-day practice is just not supported by evidence. So I think I have lots of stories where I could have done better, but I don't know that I've seen a great outcome. Mary and I have spent a lot of time talking about what would it look like, and running it by each other, and I've been talking to my friends and other clinicians about what would be feasible for actually implementing this caregiver training? And I think the things to think about are you can't do it on your own, that you need to really think about how to train caregivers well over different settings. It's everyone's responsibility. It's the acute care therapist and the rehab therapist and the home care therapist and the outpatient therapist. Everyone should be involving the caregiver and really thinking about best practice, and then also thinking about how we can involve other professions to do some of this work.

So problem solving therapy, CBT isn't just OT. It aligns well with OT, but nurses, mental health professionals and social workers, other people can also be involved and support these things across the continuum.

DR MARY HILDEBRAND:  
I agree. This was tough. I think that when I was a practitioner, I was doing what was commonly done, which is not best practice, so I didn't have a case study or personal experience to share, and that's one of the reasons we do these systematic reviews. We really are wanting to find out what is best practice.

MATT BRANDENBURG:  
Thank you so much for describing that. I really think the first step in promoting or implementing evidence-based practice into what we do as practitioners is realizing that what is most common might not be supported by evidence. We've discussed this how a lot of practitioners might feel like they're checking off that box of caregiver education, just by maybe leaving a pamphlet or giving a 30-minute instruction while still in acute care. Those points that you highlighted, Mandy, I think can be very beneficial and encourage practitioners and our listeners to attempt to advocate for more changes in their practice settings if need be, to try and establish a follow-up system. What recommendations would you have to practitioners who maybe want to make a change but aren't quite sure how to advocate and what to ask for of maybe their supervisors or other people within the organization?

DR MARY HILDEBRAND:  
I think the number one recommendation I have is the thorough assessment of the caregiver to determine what their needs are. And I think Mandy described it well in that, you have that caregiver in every session that you can and you're doing an assessment of the caregiver as well as the intervention with the client who's had a stroke. My second recommendation would be to really learn more about problem solving techniques.

DR AMANDA MACK:  
Yeah. And I think just like every caregiver and every person with a stroke is different and individual, each person's practice setting is going to be very different and there's going to be different barriers, but I think about getting some of these things into habit. The easy ways to start are expanding the occupational profile, perhaps getting your hands on an assessment that you like of the caregiver, right? And starting to use it. Thinking about how can you have your schedule done in a way that the caregivers are present as much as possible or feasible. Thinking about how do you hand off and discharge? Is there a summary about a caregiver that you can add on in communication? Can you perhaps involve doctoral students to do some caregiver training while you're hands-on with a client or can they help follow up phone calls? I don't know. I love to think creatively, but it does take effort to think about, "What does this look like in my setting?" And of course, inpatient's going to look very different from something like home care, but being willing to challenge what we've done, change the status quo in order to provide the best care for our patients and their families and their caregivers, is important.

MATT BRANDENBURG:  
Absolutely. Those are wonderful recommendations and encouraging recommendations. Thank you so much for sharing those with our listeners. I only have two more questions for you both now. The first being, where can listeners find more information related to the stroke systematic review and its clinical applications?

DR MARY HILDEBRAND:  
Well, I think AJOT has published one of the questions for the stroke systematic review that we have completed, the end of 2021. And Mandy and I have this review, and that will be published...

DR AMANDA MACK:  
The January/February issue of AJOT, so the 2023 January/February issue.

DR MARY HILDEBRAND:  
Right. But then there are four...

DR AMANDA MACK:  
Systematic review briefs.

DR MARY HILDEBRAND:  
Yes. So, those are already published in AJOT.

MATT BRANDENBURG:  
Perfect. Perfect. I'll link those articles in our episode description as well as that Family Caregiver Alliance website that you mentioned earlier. Was there any other resources you'd recommend to our listeners?

DR MARY HILDEBRAND:  
Well, I was just thinking AARP has great caregiving resources.

MATT BRANDENBURG:  
Perfect. Well, thank you so much. We're now arriving at our golden nugget segment. Personally, my favorite question of the show, if you could share one piece of advice or give one clinical recommendation to our listeners, what would you say?

DR AMANDA MACK:  
Do we each get one?

MATT BRANDENBURG:  
Yes. Yes. You can each have as many golden nuggets as you would like.

DR AMANDA MACK:  
My one piece of advice if I were to try to step back and summarize everything, is to view the caregiver as your client, to use that OT process and our OT clinical reasoning and our clinical lenses to think about how to best treat the caregiver. And that's going to lead most practitioners to some really solid interventions.

DR MARY HILDEBRAND:  
And I would say, really start looking at resources and literature about problem solving therapy, problem solving techniques, because we can't go home and be with the caregivers 24/7. They've got to learn some of these strategies to solve problems, and that's really going to be helpful to them. Start learning how to deliver problem solving techniques.

MATT BRANDENBURG:  
I love that. Those are wonderful golden nuggets to change our perspective, add to our OT toolbox, and really practice at the top of our license. Thank you both so much for your time and for being on the show today. It's really been awesome.

DR AMANDA MACK:  
Thanks so much for having us, Matt.

DR MARY HILDEBRAND:  
Thank you.

MATT BRANDENBURG:  
Absolutely.

SPEAKER:  
Thanks for listening to Everyday Evidence. Tune in next time for more evidence-based practice insights and applications.