



OCCUPATIONAL THERAPY PRACTICE
FRAMEWORK:
Domain & Process
2nd Edition



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The American Occupational Therapy Association advances occupational therapy as the pre-eminent profession in promoting the health, productivity, and quality of life of individuals and society through the therapeutic application of occupation.

AOTA Mission Statement

The American Occupational Therapy Association advances the quality, availability, use, and support of occupational therapy through standard-setting, advocacy, education, and research on behalf of its members and the public.

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INTRODUCTION

The *Occupational Therapy Practice Framework: Domain and Process, 2nd Edition (Framework–II)* is an official document of the American Occupational Therapy Association (AOTA). Intended for internal and external audiences, it presents a summary of interrelated constructs that define and guide **occupational therapy**¹ practice. The *Framework* was developed to articulate occupational therapy's contribution to promoting the **health** and **participation** of people, organizations, and populations through **engagement in occupation**. It is not a taxonomy, theory, or model of occupational therapy and therefore must be used in conjunction with the knowledge and evidence relevant to occupation and occupational therapy. The revisions included in this second edition are intended to refine the document and include language and concepts relevant to current and emerging occupational therapy practice.

Implicit within this summary are the profession's core beliefs in the positive relationship between occupation and health and its view of people as occupational beings. "All people need to be able or enabled to engage in the occupations of their need and choice, to grow through what they do, and to experience **independence** or **interdependence**, equality, participation, security, health, and well-being" (Wilcock & Townsend, 2008, p. 198). With this aim, occupational therapy is provided to **clients**, the entity that receives occupational therapy services. Clients may be categorized as

- **Persons**, including families, caregivers, teachers, employers, and relevant others;
- **Organizations**, such as businesses, industries, or agencies; and
- **Populations** within a community, such as refugees, veterans who are homeless, and people with chronic health disabling conditions (Moyers & Dale, 2007).

The *Framework* is divided into two major sections: (1) the **domain**, which outlines the profession's purview and the areas in which its mem-

¹Many of the terms that appear in **bold** are defined in the glossary.

“The *Framework* was developed to articulate occupational therapy’s contribution to promoting the health and participation of people, organizations, and populations through engagement in occupation.”

bers have an established body of knowledge and expertise (see Figure 1), and (2) the dynamic occupation and client-centered *process* used in the delivery of occupational therapy services (see Figure 2). The domain and process of occupational therapy direct occupational therapy practitioners² to focus on performance of occupations that results from the dynamic intersection of the client, the context and environment, and the client’s occupations (Christiansen & Baum, 1997; Christiansen, Baum, & Bass-Hagen, 2005; Law, Baum, & Dunn, 2005). Although the domain and process are described separately, in actuality, they are inextricably linked in a transactional relationship (see Figure 3).

Numerous resource materials, including an appendix, a glossary, references, and a bibliography, are supplied at the end of the document. Although the *Framework* includes a glossary of defined terms, it does not contain an exhaustive or uniform list of terms used in the profession nor all

of the definitions of these terms discussed in the literature.

Domain of Occupational Therapy

Overview

This edition of the *Framework* begins with a description of the occupational therapy profession’s domain. The overarching statement—**supporting health and participation in life through engagement in occupation**—describes the domain in its fullest sense. Within this diverse profession, the defining contribution of occupational therapy is the application of core values, knowledge, and skills to assist clients (people, organizations, and populations) to engage in everyday activities or occupations that they want and need to do in a manner that supports health and participation. Figure 4 identifies the aspects of the domain and illustrates the dynamic interrelatedness among them. All aspects of the domain are of equal value, and together they interact to influence the client’s engagement in occupations, participation, and health.

Occupational therapists are educated to evaluate aspects of the occupational therapy domain and their **transactional** relationships. Occupational therapists and occupational therapy assistants are educated about the aspects of the occupational therapy domain and apply this knowledge to the intervention process as they work to support the health and participation of their clients. Occupational therapists are responsible for all aspects of occupational therapy service delivery and are accountable for the safety and effectiveness of that service delivery process. Occupational therapy assistants deliver occupational therapy service under the supervision of and in collaboration with an occupational therapist (AOTA, 2004b).

²When the term *occupational therapy practitioner* is used in this document, it refers to occupational therapists and occupational therapy assistants (AOTA, 2006).

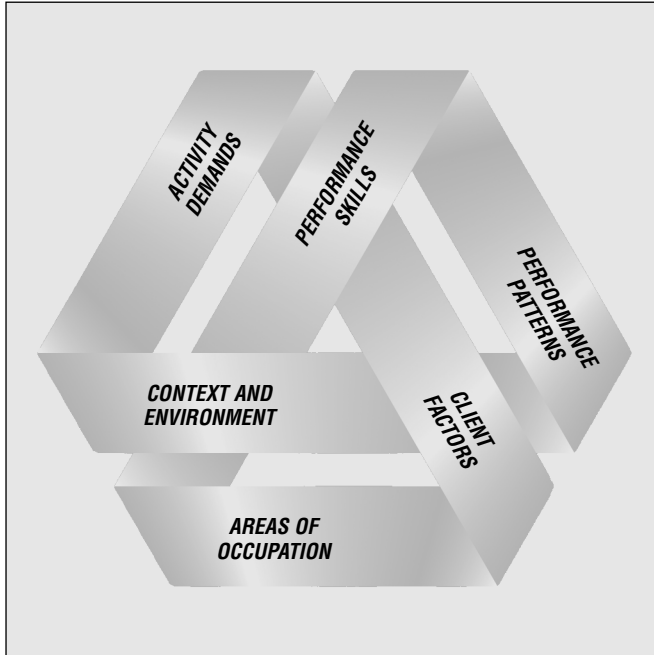


Figure 1. Occupational Therapy's Domain.
Supporting health and participation in life through engagement in occupation.

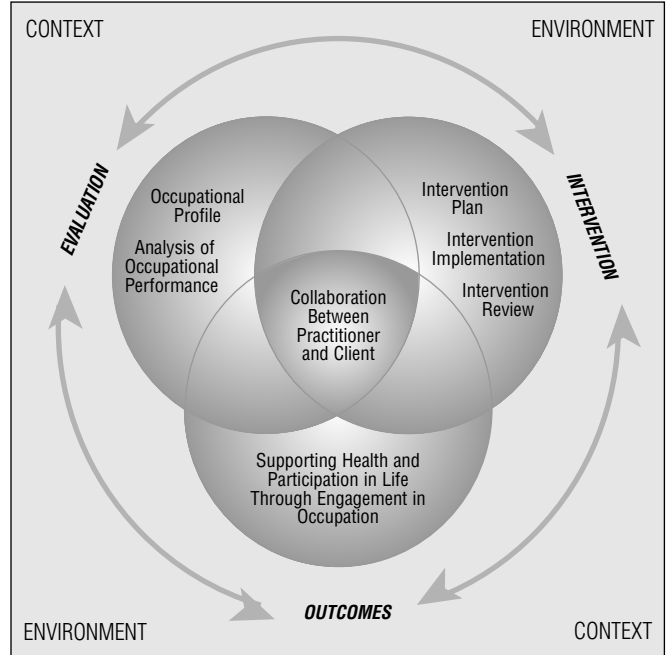


Figure 2. Occupational Therapy's Process.
Collaboration between the practitioner and the client is central to the interactive nature of service delivery.

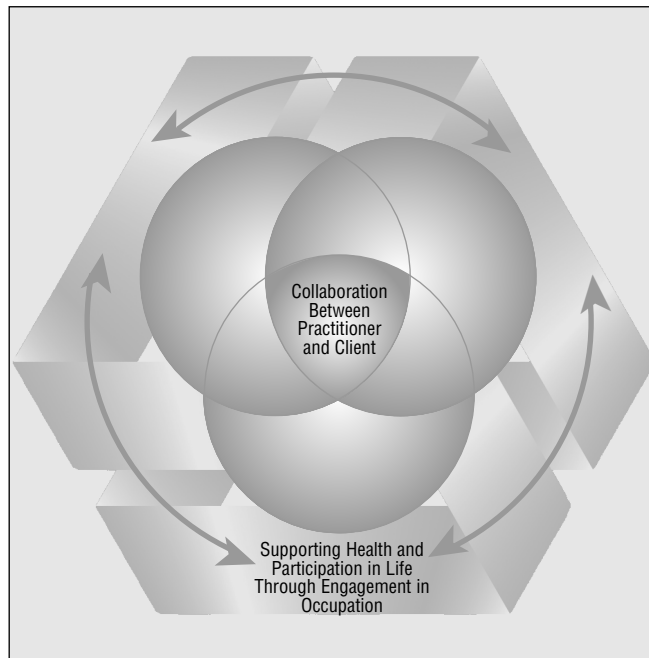


Figure 3. Occupational Therapy.
The domain and process are inextricably linked.

Note: Möbius in figures 1 and 3 originally designed by Mark Dow. Used with permission.

AREAS OF OCCUPATION	CLIENT FACTORS	PERFORMANCE SKILLS	PERFORMANCE PATTERNS	CONTEXT AND ENVIRONMENT	ACTIVITY DEMANDS
Activities of Daily Living (ADL)* Instrumental Activities of Daily Living (IADL) Rest and Sleep Education Work Play Leisure Social Participation	Values, Beliefs, and Spirituality Body Functions Body Structures	Sensory Perceptual Skills Motor and Praxis Skills Emotional Regulation Skills Cognitive Skills Communication and Social Skills	Habits Routines Roles Rituals	Cultural Personal Physical Social Temporal Virtual	Objects Used and Their Properties Space Demands Social Demands Sequencing and Timing Required Actions Required Body Functions Required Body Structures
*Also referred to as <i>basic activities of daily living (BADL)</i> or <i>personal activities of daily living (PADL)</i> .					

Figure 4. Aspects of Occupational Therapy's Domain.

All aspects of the domain transact to support engagement, participation, and health. This figure does not imply a hierarchy.

The discussion that follows provides a brief explanation of each aspect identified in Figure 4. Tables included throughout provide full lists and definitions of terms.

Supporting Health and Participation in Life Through Engagement in Occupation

The profession of occupational therapy uses the term *occupation* to capture the breadth and meaning of “everyday **activity**.” Occupational therapy is founded on an understanding that engaging in occupations structures everyday life and contributes to health and well-being. Occupational therapy practitioners believe that occupations are multidimensional and complex. Engagement in occupation as the focus of occupational therapy intervention involves addressing both subjective (emotional and psychological) and objective (physically observable) aspects of performance. Occupational therapy practitioners understand engagement from this dual and holistic perspective and address all aspects of performance when providing interventions.

Occupational science, a discipline devoted to the study of occupation, informs occupational therapy practice by expanding the understanding of occupation (Zemke & Clark, 1996). Occupations are central to a client’s (person, organization, or pop-

“All aspects of the domain are of equal value, and together they interact to influence the client’s engagement in occupations, participation, and health.”

ulation) identity and sense of competence and have particular meaning and value to the client. They influence how clients spend time making decisions. Several definitions of occupation can be found in the literature that adds to an understanding of this core concept. *Occupation* has been defined as

- “Goal-directed pursuits that typically extend over time, have meaning to the performance, and involve multiple tasks” (Christiansen et al., 2005, p. 548).
- “Daily activities that reflect cultural values, provide structure to living, and meaning to

individuals; these activities meet human needs for self-care, enjoyment, and participation in society” (Crepeau, Cohn, & Schell, 2003, p. 1031).

- “Activities that people engage in throughout their daily lives to fulfill their time and give life meaning. Occupations involve mental abilities and skills and may or may not have an observable physical dimension” (Hinojosa & Kramer, 1997, p. 865).
- “[A]ctivities...of everyday life, named, organized, and given value and meaning by individuals and a culture. Occupation is everything people do to occupy themselves, including looking after themselves...enjoying life...and contributing to the social and economic fabric of their communities” (Law, Polatajko, Baptiste, & Townsend, 1997, p. 32).
- “A dynamic relationship among an occupational form, a person with a unique developmental structure, subjective meanings and purpose, and the resulting occupational performance” (Nelson & Jepson-Thomas, 2003, p. 90).
- “[C]hunks of daily activity that can be named in the lexicon of the culture” (Zemke & Clark, 1996, p. vii).

Sometimes occupational therapy practitioners use the terms *occupation* and *activity* interchangeably to describe participation in daily life pursuits. Some scholars have proposed that the two terms are different (Christiansen & Townsend, 2004; Hinojosa & Kramer, 1997; Pierce, 2001; Reed, 2005). In the *Framework*, the term occupation encompasses activity.

Occupational engagement occurs individually or with others. A client may be considered independent when the client performs or directs the actions necessary to participate regardless of the amount or kind of assistance desired or required. In contrast with narrower definitions of indepen-

dence, occupational therapy practitioners consider a client as independent whether the client solely performs the activities, performs the activities in an adapted or modified environment, makes use of various devices or alternative strategies, or oversees activity completion by others (AOTA, 2002a). For example, people with a spinal cord injury can direct a personal care assistant to assist them with their activities of daily living (ADLs), demonstrating independence in this essential aspect of their lives.

Occupations often are shared. Those that implicitly involve two or more individuals may be termed *co-occupations* (Zemke & Clark, 1996). Care giving is a co-occupation that involves active participation on the part of the caregiver and the recipient of care. For example, the co-occupations required during mothering, such as the socially interactive routines of eating, feeding, and comforting, may involve the parent, a partner, the child, and significant others (Olsen, 2004). The activities intrinsic to this social interaction are reciprocal, interactive, and nested “co-occupations” (Dunlea, 1996; Esdaile & Olson, 2004). Clients also may perform several occupations simultaneously, enfolding them into one another such as when a caregiver concurrently helps with homework, pays the bills, and makes dinner. Consideration of co-occupation supports an integrated view of the client’s engagement in relationship to significant others within context.

Occupational therapy practitioners recognize that health is supported and maintained when clients are able to engage in occupations and activities that allow desired or needed participation in home, school, workplace, and community life. Thus, occupational therapy practitioners are concerned not only with occupations but also the complexity of factors that empower and make possible clients’ engagement and participation in positive health-promoting occupations (Wilcock &

Townsend, 2008). In 2003, Townsend applied the concept of **social justice** to occupational therapy's focus and coined the term **occupational justice** to describe the profession's concern with ethical, moral, and civic factors that can support or hinder health-promoting engagement in occupations and participation in home and community life. *Occupational justice* ensures that clients are afforded the opportunity for full participation in those occupations in which they choose to engage (Christiansen & Townsend, 2004, p. 278). Occupational therapy practitioners interested in occupational justice recognize and work to support social policies, actions, and laws that allow people to engage in occupations that provide purpose and meaning in their lives.

Occupational therapy's focus on engaging in occupations and occupational justice complements the World Health Organization's (WHO) perspective of health. WHO, in its effort to broaden the understanding of the effects of disease and disability on health, has recognized that health can be affected by the inability to carry out activities and participate in life situations caused by environmental barriers, as well as by problems that exist with body structures and body functions (WHO, 2001). As members of a global community, occupational therapy practitioners advocate for the well-being of all persons, groups, and populations with a commitment to inclusion and nondiscrimination (AOTA, 2004c).

Areas of Occupation

When occupational therapy practitioners work with clients, they consider the many types of occupations in which clients might engage. The broad range of activities or occupations are sorted into categories called "**areas of occupation**"—*activities of daily living, instrumental activities of daily living, rest and sleep, education, work, play, leisure, and social participation* (see Table 1).

Individual differences in the way in which clients view their occupations reflect the complexity and multidimensionality of each occupation. The client's perspective of how an occupation is categorized varies depending on that client's needs and interests. For example, one person may perceive doing laundry as work, while another may consider it an instrumental activity of daily living (IADL). One population may engage in a quiz game and view their participation as play, while another population may engage in the same quiz game and view it as an educational occupation.

The way in which clients prioritize engagement in areas of occupation may vary at different times. For example, a community psychiatric rehabilitation organization may prioritize member voter registration during a presidential campaign and celebration preparations during holiday periods. The extent and nature of the engagement is as important as the engagement itself; for example, excessive work without sufficient regard to other aspects of life such as sleep or relationships places clients at risk for health problems (Hakansson, Dahlin-Ivanoff, & Sonn, 2006).

Client Factors

Client factors are specific abilities, characteristics, or beliefs that reside within the client and may affect performance in areas of occupation. Because occupational therapy practitioners view clients holistically, they consider client factors that involve the values, beliefs, and spirituality; body functions; and body structures. These underlying client factors are affected by the presence or absence of illness, disease, deprivation, and disability. They affect and are affected by performance skills, performance patterns, activity demands, and contextual and environmental factors.

Despite their importance, the presence or absence of specific body functions and body

TABLE 1. AREAS OF OCCUPATION

Various kinds of life activities in which people, populations, or organizations engage, including ADL, IADL, rest and sleep, education, work, play, leisure, and social participation.

■ ACTIVITIES OF DAILY LIVING (ADLs)

Activities that are oriented toward taking care of one's own body (adapted from Rogers & Holm, 1994, pp. 181–202). ADL also is referred to as *basic activities of daily living (BADLs)* and *personal activities of daily living (PADLs)*. These activities are “fundamental to living in a social world; they enable basic survival and well-being” (Christiansen & Hammecker, 2001, p. 156).

- **Bathing, showering**—Obtaining and using supplies; soaping, rinsing, and drying body parts; maintaining bathing position; and transferring to and from bathing positions.
- **Bowel and bladder management**—Includes completing intentional control of bowel movements and urinary bladder and, if necessary, using equipment or agents for bladder control (Uniform Data System for Medical Rehabilitation, 1996, pp. III–20, III–24).
- **Dressing**—Selecting clothing and accessories appropriate to time of day, weather, and occasion; obtaining clothing from storage area; dressing and undressing in a sequential fashion; fastening and adjusting clothing and shoes; and applying and removing personal devices, prostheses, or orthoses.
- **Eating**—“The ability to keep and manipulate food or fluid in the mouth and swallow it; *eating* and *swallowing* are often used interchangeably” (AOTA, 2007b).
- **Feeding**—“The process of setting up, arranging, and bringing food [or fluid] from the plate or cup to the mouth; sometimes called *self-feeding*” (AOTA, 2007b).
- **Functional mobility**—Moving from one position or place to another (during performance of everyday activities), such as in-bed mobility, wheelchair mobility, and transfers (e.g., wheelchair, bed, car, tub, toilet, tub/shower, chair, floor). Includes functional ambulation and transporting objects.
- **Personal device care**—Using, cleaning, and maintaining personal care items, such as hearing aids, contact lenses, glasses,

orthotics, prosthetics, adaptive equipment, and contraceptive and sexual devices.

- **Personal hygiene and grooming**—Obtaining and using supplies; removing body hair (e.g., use of razors, tweezers, lotions); applying and removing cosmetics; washing, drying, combing, styling, brushing, and trimming hair; caring for nails (hands and feet); caring for skin, ears, eyes, and nose; applying deodorant; cleaning mouth; brushing and flossing teeth; or removing, cleaning, and reinserting dental orthotics and prosthetics.
- **Sexual activity**—Engaging in activities that result in sexual satisfaction.
- **Toilet hygiene**—Obtaining and using supplies; clothing management; maintaining toileting position; transferring to and from toileting position; cleaning body; and caring for menstrual and continence needs (including catheters, colostomies, and suppository management).

■ INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADLs)

Activities to support daily life within the home and community that often require more complex interactions than self-care used in ADL.

- **Care of others (including selecting and supervising caregivers)**—Arranging, supervising, or providing the care for others.
- **Care of pets**—Arranging, supervising, or providing the care for pets and service animals.
- **Child rearing**—Providing the care and supervision to support the developmental needs of a child.
- **Communication management**—Sending, receiving, and interpreting information using a variety of systems and equipment, including writing tools, telephones, typewriters, audiovisual recorders, computers, communication boards, call lights, emergency systems, Braille writers, telecommunication devices for the deaf, augmentative communication systems, and personal digital assistants.

- **Community mobility**—Moving around in the community and using public or private transportation, such as driving, walking, bicycling, or accessing and riding in buses, taxi cabs, or other transportation systems.
- **Financial management**—Using fiscal resources, including alternate methods of financial transaction and planning and using finances with long-term and short-term goals.
- **Health management and maintenance**—Developing, managing, and maintaining routines for health and wellness promotion, such as physical fitness, nutrition, decreasing health risk behaviors, and medication routines.
- **Home establishment and management**—Obtaining and maintaining personal and household possessions and environment (e.g., home, yard, garden, appliances, vehicles), including maintaining and repairing personal possessions (clothing and household items) and knowing how to seek help or whom to contact.
- **Meal preparation and cleanup**—Planning, preparing, and serving well-balanced, nutritional meals and cleaning up food and utensils after meals.
- **Religious observance**—Participating in *religion*, “an organized system of beliefs, practices, rituals, and symbols designed to facilitate closeness to the sacred or transcendent” (Moreira-Almeida & Koenig, 2006, p. 844).
- **Safety and emergency maintenance**—Knowing and performing preventive procedures to maintain a safe environment as well as recognizing sudden, unexpected hazardous situations and initiating emergency action to reduce the threat to health and safety.
- **Shopping**—Preparing shopping lists (grocery and other); selecting, purchasing, and transporting items; selecting method of payment; and completing money transactions.

(Continued)

TABLE 1. AREAS OF OCCUPATION*(Continued)***■ REST AND SLEEP**

Includes activities related to obtaining restorative rest and sleep that supports healthy active engagement in other areas of occupation.

- **Rest**—Quiet and effortless actions that interrupt physical and mental activity resulting in a relaxed state (Nurit & Michel, 2003, p. 227). Includes identifying the need to relax; reducing involvement in taxing physical, mental, or social activities; and engaging in relaxation or other endeavors that restore energy, calm, and renewed interest in engagement.
- **Sleep**—A series of activities resulting in going to sleep, staying asleep, and ensuring health and safety through participation in sleep involving engagement with the physical and social environments.
- **Sleep preparation**—(1) Engaging in routines that prepare the self for a comfortable rest, such as grooming and undressing, reading or listening to music to fall asleep, saying goodnight to others, and meditation or prayers; determining the time of day and length of time desired for sleeping or the time needed to wake; and establishing sleep patterns that support growth and health (patterns are often personally and culturally determined).
(2) Preparing the physical environment for periods of unconsciousness, such as making the bed or space on which to sleep; ensuring warmth/coolness and protection; setting an alarm clock; securing the home, such as locking doors or closing windows or curtains; and turning off electronics or lights.
- **Sleep participation**—Taking care of personal need for sleep such as cessation of activities to ensure onset of sleep, napping, dreaming, sustaining a sleep state without disruption, and nighttime care of toileting needs or hydration. Negotiating the needs and requirements of others within the social environment. Interacting with those sharing the sleeping space such as children or partners, providing nighttime care giving such as breastfeeding, and monitoring the com-

fort and safety of others such as the family while sleeping.

■ EDUCATION

Includes activities needed for learning and participating in the environment.

- **Formal educational participation**—Including the categories of academic (e.g., math, reading, working on a degree), nonacademic (e.g., recess, lunchroom, hallway), extracurricular (e.g., sports, band, cheerleading, dances), and vocational (pre-vocational and vocational) participation.
- **Informal personal educational needs or interests exploration (beyond formal education)**—Identifying topics and methods for obtaining topic-related information or skills.
- **Informal personal education participation**—Participating in classes, programs, and activities that provide instruction/training in identified areas of interest.

■ WORK

Includes activities needed for engaging in remunerative employment or volunteer activities (Mosey, 1996, p. 341).

- **Employment interests and pursuits**—Identifying and selecting work opportunities based on assets, limitations, likes, and dislikes relative to work (adapted from Mosey, 1996, p. 342).
- **Employment seeking and acquisition**—Identifying and recruiting for job opportunities; completing, submitting, and reviewing appropriate application materials; preparing for interviews; participating in interviews and following up afterward; discussing job benefits; and finalizing negotiations.
- **Job performance**—Job performance including work skills and patterns; time management; relationships with co-workers, managers, and customers; creation, production, and distribution of products and services; initiation, sustainment, and completion of work; and compliance with work norms and procedures.

- **Retirement preparation and adjustment**—Determining aptitudes, developing interests and skills, and selecting appropriate avocational pursuits.
- **Volunteer exploration**—Determining community causes, organizations, or opportunities for unpaid “work” in relationship to personal skills, interests, location, and time available.
- **Volunteer participation**—Performing unpaid “work” activities for the benefit of identified selected causes, organizations, or facilities.

■ PLAY

“Any spontaneous or organized activity that provides enjoyment, entertainment, amusement, or diversion” (Parham & Fazio, 1997, p. 252).

- **Play exploration**—Identifying appropriate play activities, which can include exploration play, practice play, pretend play, games with rules, constructive play, and symbolic play (adapted from Bergen, 1988, pp. 64–65).
- **Play participation**—Participating in play; maintaining a balance of play with other areas of occupation; and obtaining, using, and maintaining toys, equipment, and supplies appropriately.

■ LEISURE

“A nonobligatory activity that is intrinsically motivated and engaged in during discretionary time, that is, time not committed to obligatory occupations such as work, self-care, or sleep” (Parham & Fazio, 1997, p. 250).

- **Leisure exploration**—Identifying interests, skills, opportunities, and appropriate leisure activities.
- **Leisure participation**—Planning and participating in appropriate leisure activities; maintaining a balance of leisure activities with other areas of occupation; and obtaining, using, and maintaining equipment and supplies as appropriate.

TABLE 1. AREAS OF OCCUPATION*(Continued)***■ SOCIAL PARTICIPATION**

“Organized patterns of behavior that are characteristic and expected of an individual or a given position within a social system”

(Mosey, 1996, p. 340).

- **Community**—Engaging in activities that result in successful interaction at the community level (i.e., neighborhood, organizations, work, school).

- **Family**—Engaging in “[activities that result in] successful interaction in specific required and/or desired familial roles” (Mosey, 1996, p. 340).
- **Peer, friend**—Engaging in activities at different levels of intimacy, including

Note. Some of the terms used in this table are from, or adapted from, the rescinded *Uniform Terminology for Occupational Therapy—Third Edition* (AOTA, 1994, pp. 1047–1054).

structures do not necessarily ensure a client’s success or difficulty with daily life occupations. Factors that influence performance such as supports in the physical or social environment may allow a client to manifest skills in a given area even when body functions or structure are absent or deficient. It is in the process of observing a client engaging in occupations and activities that the occupational therapy practitioner is able to determine the transaction between client factors and performance.

Client factors are substantively different at the person, organization, and population levels. Following are descriptions of client factors for each level.

Person

- **Values, beliefs, and spirituality** influence a client’s motivation to engage in occupations and give his or her life meaning. *Values* are principles, standards, or qualities considered worthwhile by the client who holds them. *Beliefs* are cognitive content held as true (Moyers & Dale, 2007, p. 28). *Spirituality* is “the personal quest for understanding answers to ultimate questions about life, about meaning and about relationship with the sacred or transcendent, which may (or may not) lead to or arise from the development of religious rituals and the formation of community” (Moreira-Almeida & Koenig, 2006, p. 844).

- **Body functions** refer to the “physiological function of body systems (including psychological functions)” (WHO, 2001, p. 10). Examples include sensory, mental (affective, cognitive, perceptual), cardiovascular, respiratory, and endocrine functions (see Table 2 for complete list).
- **Body structures** are the “anatomical parts of the body such as organs, limbs, and their components” (WHO, 2001, p. 10). Body structures and body functions are interrelated (e.g., the heart and blood vessels are body structures that support cardiovascular function; see Table 2). The categorization of body function and body structure client factors outlined in Table 2 is based on the *International Classification of Functioning, Disability, and Health* proposed by the WHO (2001). The classification was selected because it has received wide exposure and presents a language that is understood by external audiences.

Organization

- *Values and beliefs* include the vision statement, code of ethics, value statements, and esprit de corps.
- *Functions* include planning, organizing, coordinating, and operationalizing the mission, products or services, and productivity.
- *Structures* include departments and departmental relationships, leadership and management, performance measures, and job titles.

Population

- *Values and beliefs* can be viewed as including emotional, purposive, and traditional perspectives (Foucault, 1973).
- *Functions* include economic, political, social, and cultural capital (Weber, 1978).
- *Structure* may include constituents such as those with similar genetics, sexual orientation, and health-related conditions (Baum, Bass-Haugen, & Christiansen, 2005, p. 381).

Activity Demands

Activity demands refer to the specific features of an activity that influence the type and amount of effort required to perform the activity. Occupational therapy practitioners analyze activities to understand what is required of the client and determine the relationship of the activity's requirements to engagement in occupation. Activity demands include the specific objects and their properties used in the activity, the physical space requirements of the activity,

TABLE 2. CLIENT FACTORS

Client factors include (1) values, beliefs, and spirituality; (2) body functions; and (3) body structures that reside within the client and may affect performance in areas of occupation.

■ VALUES, BELIEFS, AND SPIRITUALITY

Category and Definition	Examples
<p>Values: Principles, standards, or qualities considered worthwhile or desirable by the client who holds them.</p>	<p>Person</p> <ol style="list-style-type: none"> 1. Honesty with self and with others 2. Personal religious convictions 3. Commitment to family. <p>Organization</p> <ol style="list-style-type: none"> 1. Obligation to serve the community 2. Fairness. <p>Population</p> <ol style="list-style-type: none"> 1. Freedom of speech 2. Equal opportunities for all 3. Tolerance toward others.
<p>Beliefs: Cognitive content held as true.</p>	<p>Person</p> <ol style="list-style-type: none"> 1. He or she is powerless to influence others 2. Hard work pays off. <p>Organization</p> <ol style="list-style-type: none"> 1. Profits are more important than people 2. Achieving the mission of providing service can effect positive change in the world. <p>Population</p> <ol style="list-style-type: none"> 1. People can influence government by voting 2. Accessibility is a right, not a privilege.
<p>Spirituality: The "personal quest for understanding answers to ultimate questions about life, about meaning, and the sacred" (Moyers & Dale, 2007, p. 28).</p>	<p>Person</p> <ol style="list-style-type: none"> 1. Daily search for purpose and meaning in one's life 2. Guiding actions from a sense of value beyond the personal acquisition of wealth or fame. <p>Organization and Population (see "Person" examples related to individuals within an organization and population).</p>

TABLE 2. CLIENT FACTORS*(Continued)*

■ **BODY FUNCTIONS:** “[T]he physiological functions of body systems (including psychological functions)” (WHO, 2001, p. 10). The “Body Functions” section of the table below is organized according to the classifications of the *International Classification of Functioning, Disability, and Health (ICF)* classifications. For fuller descriptions and definitions, refer to WHO (2001).

Categories	Body Functions Commonly Considered by Occupational Therapy Practitioners (<i>Not intended to be all-inclusive list</i>)
<p>Mental functions (affective, cognitive, perceptual)</p> <ul style="list-style-type: none"> • Specific mental functions <ul style="list-style-type: none"> ○ Higher-level cognitive ○ Attention ○ Memory ○ Perception ○ Thought ○ Mental functions of sequencing complex movement ○ Emotional ○ Experience of self and time • Global mental functions <ul style="list-style-type: none"> ○ Consciousness ○ Orientation ○ Temperament and personality ○ Energy and drive ○ Sleep (physiological process) 	<p>Specific mental functions</p> <p>Judgment, concept formation, metacognition, cognitive flexibility, insight, attention, awareness</p> <p>Sustained, selective, and divided attention</p> <p>Short-term, long-term, and working memory</p> <p>Discrimination of sensations (e.g., auditory, tactile, visual, olfactory, gustatory, vestibular–proprioception), including multi-sensory processing, sensory memory, spatial, and temporal relationships (Calvert, Spence, & Stein, 2004)</p> <p>Recognition, categorization, generalization, awareness of reality, logical/coherent thought, and appropriate thought content</p> <p>Execution of learned movement patterns</p> <p>Coping and behavioral regulation (Schell, Cohn, & Crepeau, 2008)</p> <p>Body image, self-concept, self-esteem</p> <p>Global mental functions</p> <p>Level of arousal, level of consciousness</p> <p>Orientation to person, place, time, self, and others</p> <p>Emotional stability</p> <p>Motivation, impulse control, and appetite</p>
<p>Sensory functions and pain</p> <ul style="list-style-type: none"> • Seeing and related functions, including visual acuity, visual stability, visual field functions • Hearing functions • Vestibular functions • Taste functions • Smell functions • Proprioceptive functions • Touch functions • Pain (e.g., diffuse, dull, sharp, phantom) • Temperature and pressure 	<p>Sensory functions and pain</p> <p>Detection/registration, modulation, and integration of sensations from the body and environment</p> <p>Visual awareness of environment at various distances</p> <p>Tolerance of ambient sounds; awareness of location and distance of sounds such as an approaching car</p> <p>Sensation of securely moving against gravity</p> <p>Association of taste</p> <p>Association of smell</p> <p>Awareness of body position and space</p> <p>Comfort with the feeling of being touched by others or touching various textures such as food</p> <p>Localizing pain</p> <p>Thermal awareness</p>

(continued)

TABLE 2. CLIENT FACTORS*(Continued)***BODY FUNCTIONS:** *(Continued)*

Categories	Body Functions Commonly Considered by Occupational Therapy Practitioners (Not intended to be all-inclusive list)
Neuromusculoskeletal and movement-related functions	Neuromusculoskeletal and movement-related functions
<ul style="list-style-type: none"> • Functions of joints and bones <ul style="list-style-type: none"> ○ Joint mobility ○ Joint stability ○ Muscle power ○ Muscle tone ○ Muscle endurance ○ Motor reflexes ○ Involuntary movement reactions ○ Control of voluntary movement ○ Gait patterns 	<p>Joint range of motion</p> <p>Postural alignment (this refers to the physiological stability of the joint related to its structural integrity as compared to the motor skill of aligning the body while moving in relation to task objects)</p> <p>Strength</p> <p>Degree of muscle tone (e.g., flaccidity, spasticity, fluctuating)</p> <p>Endurance</p> <p>Stretch, asymmetrical tonic neck, symmetrical tonic neck</p> <p>Righting and supporting</p> <p>Eye–hand/foot coordination, bilateral integration, crossing the midline, fine- and gross-motor control, and oculomotor (e.g., saccades, pursuits, accommodation, binocularity)</p> <p>Walking patterns and impairments such as asymmetric gait, stiff gait. (<i>Note:</i> Gait patterns are considered in relation to how they affect ability to engage in occupations in daily life activities.)</p>
Cardiovascular, hematological, immunological, and respiratory system function	Cardiovascular, hematological, immunological, and respiratory system function
<ul style="list-style-type: none"> • Cardiovascular system function • Hematological and immunological system function • Respiratory system function • Additional functions and sensations of the cardiovascular and respiratory systems 	<p>Blood pressure functions (hypertension, hypotension, postural hypotension), and heart rate</p> <p>(<i>Note:</i> Occupational therapy practitioners have knowledge of these body functions and understand broadly the interaction that occurs between these functions to support health and participation in life through engagement in occupation. Some therapists may specialize in evaluating and intervening with a specific function as it is related to supporting performance and engagement in occupations and activities targeted for intervention.)</p> <p>Rate, rhythm, and depth of respiration</p> <p>Physical endurance, aerobic capacity, stamina, and fatigability</p>
Voice and speech functions	<p>(<i>Note:</i> Occupational therapy practitioners have knowledge of these body functions and understand broadly the interaction that occurs between these functions to support health and participation in life through engagement in occupation. Some therapists may specialize in evaluating and intervening with a specific function, such as incontinence and pelvic floor disorders, as it is related to supporting performance and engagement in occupations and activities targeted for intervention.)</p>
Digestive, metabolic, and endocrine system function	
<ul style="list-style-type: none"> • Digestive system function • Metabolic system and endocrine system function 	
Genitourinary and reproductive functions	
<ul style="list-style-type: none"> • Urinary functions • Genital and reproductive functions 	

TABLE 2. CLIENT FACTORS

(Continued)

■ BODY FUNCTIONS: (Continued)

Categories	Body Functions Commonly Considered by Occupational Therapy Practitioners (<i>Not intended to be all-inclusive list</i>)
Skin and related-structure functions	Skin and related-structure functions
<ul style="list-style-type: none"> • Skin functions • Hair and nail functions 	<p>Protective functions of the skin—presence or absence of wounds, cuts, or abrasions</p> <p>Repair function of the skin—wound healing</p> <p>(<i>Note:</i> Occupational therapy practitioners have knowledge of these body functions and understand broadly the interaction that occurs between these functions to support health and participation in life through engagement in occupation. Some therapists may specialize in evaluating and intervening with a specific function as it is related to supporting performance and engagement in occupations and activities targeted for intervention.)</p>

■ **BODY STRUCTURES:** *Body structures* are “anatomical parts of the body, such as organs, limbs, and their components [that support body function]” (WHO, 2001, p. 10). The “Body Structures” section of the table below is organized according to the *ICF* classifications. For fuller descriptions and definitions, refer to WHO (2001).

Categories	Examples are not delineated in the “Body Structure” section of this table.
<p>Structure of the nervous system</p> <p>Eyes, ear, and related structures</p> <p>Structures involved in voice and speech</p> <p>Structures of the cardiovascular, immunological, and respiratory systems</p> <p>Structures related to the digestive, metabolic, and endocrine systems</p> <p>Structure related to the genitourinary and reproductive systems</p> <p>Structures related to movement</p> <p>Skin and related structures</p>	<p>(<i>Note:</i> Occupational therapy practitioners have knowledge of body structures and understand broadly the interaction that occurs between these structures to support health and participation in life through engagement in occupation. Some therapists may specialize in evaluating and intervening with a specific structure as it is related to supporting performance and engagement in occupations and activities targeted for intervention.)</p>

Note. Some data adapted from the *ICF* (WHO, 2001).

TABLE 3. ACTIVITY DEMANDS

The aspects of an activity, which include the objects and their properties, space, social demands, sequencing or timing, required actions and skills, and required underlying body functions and body structure needed to carry out the activity.

Activity Demand Aspects	Definition	Examples
Objects and their properties	Tools, materials, and equipment used in the process of carrying out the activity	<ul style="list-style-type: none"> • Tools (e.g., scissors, dishes, shoes, volleyball) • Materials (e.g., paints, milk, lipstick) • Equipment (e.g., workbench, stove, basketball hoop) • Inherent properties (e.g., heavy, rough, sharp, colorful, loud, bitter tasting)
Space demands (relates to physical context)	Physical environmental requirements of the activity (e.g., size, arrangement, surface, lighting, temperature, noise, humidity, ventilation)	<ul style="list-style-type: none"> • Large, open space outdoors required for a baseball game • Bathroom door and stall width to accommodate wheelchair • Noise, lighting, and temperature controls for a library
Social demands (relates to social environment and cultural contexts)	Social environment and cultural contexts that may be required by the activity	<ul style="list-style-type: none"> • Rules of game • Expectations of other participants in activity (e.g., sharing supplies, using language appropriate for the meeting)
Sequence and timing	Process used to carry out the activity (e.g., specific steps, sequence, timing requirements)	<ul style="list-style-type: none"> • <i>Steps to make tea:</i> Gather cup and tea bag, heat water, pour water into cup, and so forth. <ul style="list-style-type: none"> ○ <i>Sequence:</i> Heat water before placing tea bag in water. ○ <i>Timing:</i> Leave tea bag to steep for 2 minutes. • <i>Steps to conduct a meeting:</i> Establish goals for meeting, arrange time and location for meeting, prepare meeting agenda, call meeting to order. <ul style="list-style-type: none"> ○ <i>Sequence:</i> Have people introduce themselves before beginning discussion of topic. ○ <i>Timing:</i> Allot sufficient time for discussion of topic and determination of action items.
Required actions and performance skills	The usual skills that would be required by any performer to carry out the activity. Sensory, perceptual, motor, praxis, emotional, cognitive, communication, and social performance skills should each be considered. The performance skills demanded by an activity will be correlated with the demands of the other activity aspects (e.g., objects, space)	<ul style="list-style-type: none"> • Feeling the heat of the stove • Gripping handlebar • Choosing the ceremonial clothes • Determining how to move limbs to control the car • Adjusting the tone of voice • Answering a question
Required body functions	“[P]hysiological functions of body systems (including psychological functions)” (WHO, 2001, p. 10) that are required to support the actions used to perform the activity	<ul style="list-style-type: none"> • Mobility of joints • Level of consciousness
Required body structures	“Anatomical parts of the body such as organs, limbs, and their components [that support body function]” (WHO, 2001, p. 10) that are required to perform the activity	<ul style="list-style-type: none"> • Number of hands • Number of eyes

the social demands, sequence and timing, the required actions or skills needed to perform the activity, and the required body functions and structures used during the performance of the activity (see Table 3 for definitions and examples.)

Activity demands are specific to each activity. A change in one feature of an activity may change the extent of the demand in another feature. For example, an increase in the number of the steps or sequence of steps in an activity increases the demand on attention skills.

Performance Skills

Various approaches have been used to describe and categorize *performance skills*. The occupational therapy literature from research and practice offers multiple perspectives on the complexity and types of skills used during performance.

According to Fisher (2006), *performance skills* are observable, concrete, goal-directed actions clients use to engage in daily life occupations. Fisher further defines these skills as small, measurable units in a chain of actions that are observed as a person performs meaningful tasks. They are learned and developed over time and are situated in specific contexts and environments. Fisher categorized performance skills as follows: Motor Skills, Process Skills, and Communication/Interaction Skills. Rogers and Holm (2008) have proposed that during task-specific performance skills, various body functions and structures coalesce into unique combinations and emerge to affect performance in real life.

Given that **performance skills** are described and categorized in multiple ways, within the *Occupational Therapy Practice Framework* they are defined as the abilities clients demonstrate in the actions they perform. The categories of a person's performance skills are interrelated and include

- **Motor and praxis skills**
- **Sensory–perceptual skills**

- **Emotional regulation skills**
- **Cognitive skills**
- **Communication and social skills.**

Numerous body functions and structures underlie and enable performance (Rogers & Holm, 2008). Whereas body functions such as mental (affective, cognitive, perceptual), sensory, neuromuscular, and movement-related body functions (WHO, 2001) reflect the capacities that reside within the body, performance skills are the clients' demonstrated abilities. For example, praxis skills can be observed through client actions such as imitating, sequencing, and constructing; cognitive skills can be observed as the client demonstrates organization, time management, and safety; and emotional regulation skills can be observed through the behaviors the client displays to express emotion appropriately. Numerous body functions underlie each performance skill.

Multiple factors, such as the context in which the occupation is performed, the specific demands of the activity being attempted, and the client's body functions and structures, affect the client's ability to acquire or demonstrate performance skills. Performance skills are closely linked and are used in combination with one another to allow the client to perform an occupation. A change in one performance skill can affect other performance skills. In practice and in some literature, performance skills often are labeled in various combinations such as perceptual–motor skills and social–emotional skills. Table 4 provides definitions and selected examples under each category.

Occupational therapy practitioners observe and analyze performance skills in order to understand the transactions among underlying factors that support or hinder engagement in occupations and occupational performance. For example, when observing a person writing a check, the occupational therapy practitioner observes the

TABLE 4. PERFORMANCE SKILLS

Performance skills are the abilities clients demonstrate in the actions they perform.

Skill	Definition	Examples
Motor and praxis skills	<p><i>Motor:</i> Actions or behaviors a client uses to move and physically interact with tasks, objects, contexts, and environments (adapted from Fisher, 2006). Includes planning, sequencing, and executing new and novel movements.</p> <p><i>Praxis:</i> Skilled purposeful movements (Heilman & Rothi, 1993). Ability to carry out sequential motor acts as part of an overall plan rather than individual acts (Liepmann, 1920). Ability to carry out learned motor activity, including following through on a verbal command, visual–spatial construction, ocular and oral–motor skills, imitation of a person or an object, and sequencing actions (Ayes, 1985; Filley, 2001). Organization of temporal sequences of actions within the spatial context, which form meaningful occupations (Blanche & Parham, 2002).</p>	<ul style="list-style-type: none"> • <i>Bending and reaching</i> for a toy or tool in a storage bin • <i>Pacing</i> tempo of movements to clean the room • <i>Coordinating</i> body movements to complete a job task • <i>Maintaining balance</i> while walking on an uneven surface or while showering • <i>Anticipating or adjusting posture and body position</i> in response to environmental circumstances, such as obstacles • <i>Manipulating</i> keys or lock to open the door
Sensory–perceptual skills	<p>Actions or behaviors a client uses to locate, identify, and respond to sensations and to select, interpret, associate, organize, and remember sensory events based on discriminating experiences through a variety of sensations that include visual, auditory, proprioceptive, tactile, olfactory, gustatory, and vestibular.</p>	<ul style="list-style-type: none"> • <i>Positioning the body</i> in the exact location for a safe jump • <i>Hearing and locating</i> the voice of your child in a crowd • <i>Visually</i> determining the correct size of a storage container for leftover soup • <i>Locating</i> keys by touch from many objects in a pocket or purse (i.e., <i>stereognosis</i>) • <i>Timing the appropriate moment</i> to cross the street safely by determining one’s own position and speed relative to the speed of traffic • <i>Discerning</i> distinct flavors within foods or beverages
Emotional regulation skills	<p>Actions or behaviors a client uses to identify, manage, and express feelings while engaging in activities or interacting with others</p>	<ul style="list-style-type: none"> • <i>Responding</i> to the feelings of others by acknowledgment or showing support • <i>Persisting</i> in a task despite frustrations • <i>Controlling</i> anger toward others and reducing aggressive acts • <i>Recovering</i> from a hurt or disappointment without lashing out at others • <i>Displaying</i> the emotions that are appropriate for the situation • <i>Utilizing</i> relaxation strategies to cope with stressful events
Cognitive skills	<p>Actions or behaviors a client uses to plan and manage the performance of an activity</p>	<ul style="list-style-type: none"> • <i>Judging</i> the importance or appropriateness of clothes for the circumstance • <i>Selecting</i> tools and supplies needed to clean the bathroom • <i>Sequencing</i> tasks needed for a school project • <i>Organizing</i> activities within the time required to meet a deadline • <i>Prioritizing</i> steps and <i>identifying</i> solutions to access transportation • <i>Creating</i> different activities with friends that are fun, novel, and enjoyable • <i>Multitasking</i>—doing more than one thing at a time, necessary for tasks such as work, driving, and household management

TABLE 4. PERFORMANCE SKILLS*(Continued)*

Skill	Definition	Examples
Communication and social skills	Actions or behaviors a person uses to communicate and interact with others in an interactive environment (Fisher, 2006)	<ul style="list-style-type: none"> • <i>Looking</i> where someone else is pointing or gazing • <i>Gesturing</i> to emphasize intentions • <i>Maintaining</i> acceptable physical space during conversation • <i>Initiating and answering</i> questions with relevant information • <i>Taking turns</i> during an interchange with another person verbally and physically • <i>Acknowledging</i> another person's perspective during an interchange

motor skills of gripping and manipulating objects and the cognitive skills of initiating and sequencing the steps of the activity. The observed skills are supported by underlying body functions related to movement and cognition and by the environmental context of the bank. Proficient occupational performance observed in playing a game of tennis or playing the piano requires multiple sets of performance skills.

Further resources informing occupational therapy practice related to performance skills include Fisher (2006); Bloom, Krathwohl, and Masia (1984); Harrow (1972); and Chapparo and Ranka (1997). Detailed information about the way that skills are used in occupational therapy practice also may be found in the literature on specific theories such as sensory integration theory (Ayres, 1972, 2005) and motor learning and motor control theory (Shumway-Cook & Wollacott, 2007).

Performance Patterns

Performance patterns refer to **habits, routines, roles, and rituals** used in the process of engaging in occupations or activities. *Habits* refer to specific, automatic behaviors that can be useful, dominating, or impoverished (Clark, 2000; Neistadt & Crepeau, 1998), whereas *routines* are established sequences of occupations or activities that provide a structure for daily life. Routines also can be

health promoting or damaging (Fiese et al., 2002; Segal, 2004). *Roles* are sets of behaviors expected by society, shaped by culture, and may be further conceptualized and defined by the client. Roles can provide guidance in selecting occupations or can lead to stereotyping and restricted engagement patterns. Jackson (1998a, 1998b) cautioned that describing people by their roles can be limiting and can promote segmented rather than

“...only occupational
therapy practitioners
focus this process
toward the end-goal of
supporting health and
participation in life
through engagement
in occupations.”

enfolded occupations. When considering roles within occupational therapy, occupational therapy practitioners are concerned with the way clients construct their occupations to fulfill their perceived roles and identity and reinforce their

“Occupational therapy practitioners apply theory, evidence, knowledge, and skills regarding the therapeutic use of occupations to positively affect the client’s health, well-being, and life satisfaction.”

values and beliefs. *Rituals* are symbolic actions with spiritual, cultural, or social meaning that contribute to the client’s identity and reinforce the client’s values and beliefs (Fiese et al., 2002; Segal, 2004). Habits, routines, roles, and rituals can support or hinder occupational performance.

People, organizations, and populations demonstrate performance patterns in daily life. They develop over time and are influenced by all other aspects of the domain. When practitioners consider the client’s patterns of performance, they are better able to understand the frequency and manner in which performance skills and occupations are integrated into the client’s life. While a client may have the ability or capacity for skilled performance, if he or she does not embed those skills in a productive set of engagement patterns, health and participation may be negatively affected. For example, a client who has the skills and resources to engage in appropriate grooming, bathing, and meal preparation but does not embed them into a consistent

routine, may struggle with poor nutrition and social isolation. Tables 5a, 5b, and 5c provide examples of performance patterns for persons, organizations, and populations.

Context and Environment

A client’s engagement in occupation takes place within a social and physical environment situated within context. In the literature, the terms *environment* and *context* often are used interchangeably. In the *Framework*, both terms are used to reflect the importance of considering the wide variety of interrelated conditions both internal and external to the client that influence performance.

The term *environment* refers to the external physical and social environments that surround the client and in which the client’s daily life occupations occur. *Physical environment* refers to the natural and built nonhuman environment and the objects in them. The *social environment* is constructed by the presence, relationships, and expectations of persons, groups, and organizations with whom the client has contact.

The term *context* refers to a variety of interrelated conditions that are within and surrounding the client. These interrelated contexts often are less tangible than physical and social environments but nonetheless exert a strong influence on performance. Contexts, as described in the *Framework*, are **cultural, personal, temporal, and virtual**. *Cultural context* includes customs, beliefs, activity patterns, behavior standards, and expectations accepted by the society of which the client is a member. *Personal context* refers to demographic features of the individual such as age, gender, socioeconomic status, and educational level that are not part of a health condition (WHO, 2001). *Temporal context* includes stages of life, time of day or year, duration, rhythm of activity, or history. *Virtual context* refers to interactions in simulated, real-time, or near-time situ-

TABLE 5A. PERFORMANCE PATTERNS—PERSON

Patterns of behavior related to an individual's or significant other's daily life activities that are habitual or routine.

	Examples
<p>HABITS—“Automatic behavior that is integrated into more complex patterns that enable people to function on a day-to-day basis” (Neistadt & Crepeau, 1998, p. 869). Habits can be useful, dominating, or impoverished and either support or interfere with performance in areas of occupation.</p>	<ul style="list-style-type: none"> – Automatically puts car keys in the same place. – Spontaneously looks both ways before crossing the street – Repeatedly rocks back and forth when asked to initiate a task – Repeatedly activates and deactivates the alarm system before entering the home – Maintains the exact distance between all hangers when hanging clothes in a closet
<p>ROUTINES—Patterns of behavior that are observable, regular, repetitive, and that provide structure for daily life. They can be satisfying, promoting, or damaging. Routines require momentary time commitment and are embedded in cultural and ecological contexts (Fiese et al., 2002; Segal, 2004).</p>	<ul style="list-style-type: none"> – Follows the morning sequence to complete toileting, bathing, hygiene, and dressing – Follows the sequence of steps involved in meal preparation
<p>RITUALS—Symbolic actions with spiritual, cultural, or social meaning, contributing to the client's identity and reinforcing values and beliefs. Rituals have a strong affective component and represent a collection of events (Fiese et al., 2002; Segal, 2004).</p>	<ul style="list-style-type: none"> – Uses the inherited antique hairbrush and brushes her hair with 100 strokes nightly as her mother had done – Prepares the holiday meals with favorite or traditional <i>accoutrements</i>, using designated dishware – Kisses a sacred book before opening the pages to read
<p>ROLES—A set of behaviors expected by society, shaped by culture, and may be further conceptualized and defined by the client.</p>	<ul style="list-style-type: none"> – Mother of an adolescent with developmental disabilities – Student with learning disability studying computer technology – Corporate executive returning to work after experiencing a stroke

Note. Information for “Habits” section of this table adapted from Dunn (2000b).

TABLE 5B. PERFORMANCE PATTERNS—ORGANIZATION

Patterns of behavior related to the daily functioning of an organization.

	Examples
<p>ROUTINES—Patterns of behavior that are observable, regular, repetitive, and that provide structure for daily life. They can be satisfying, promoting, or damaging. Routines require momentary time commitment and are embedded in cultural and ecological contexts (Fiese et al., 2002; Segal, 2004).</p>	<ul style="list-style-type: none"> – Holds regularly scheduled meetings for staff, directors, executive boards – Follows documentation practices for annual reports, timecards, and strategic plans – Turns in documentation on a scheduled basis – Follows the chain of command – Follows safety and security routines (e.g., signing in/out, using pass codes) – Maintains dress codes (e.g., casual Fridays) – Socializes during breaks, lunch, at the water cooler – Follows beginning or ending routines (e.g., opening/closing the facility) – Offers activities to meet performance expectations or standards

(Continued)

TABLE 5B. PERFORMANCE PATTERNS—ORGANIZATION

(Continued)

	Examples
RITUALS —Symbolic actions that have meaning, contributing to the organization's identity and reinforcing values and beliefs (adapted from Fiese et al., 2002; Segal, 2004).	<ul style="list-style-type: none">– Holds holiday parties, company picnics– Conducts induction, recognition, and retirement ceremonies– Organizes annual retreats or conferences– Maintains fundraising activities for organization to support local charities
ROLES —A set of behaviors by the organization expected by society, shaped by culture, and may be further conceptualized and defined by the client.	<ul style="list-style-type: none">– Nonprofit organization provides housing for persons living with mental illness– Humanitarian organization distributes food and clothing donations to refugees– University educates and provides service to the surrounding community

Note. In this document, habits are addressed only in Table 5A (Person).

TABLE 5C. PERFORMANCE PATTERNS—POPULATION

Patterns of behavior related to a population.

	Examples
ROUTINES —Patterns of behavior that are observable, regular, repetitive, and that provide structure for daily life. They can be satisfying, promoting, or damaging. Routines require momentary time commitment and are embedded in cultural and ecological contexts (Fiese et al., 2002; Segal, 2004).	<ul style="list-style-type: none">– Follows health practices, such as scheduled immunizations for children and yearly health screenings for adults– Follows business practices, such as provision of services for the disadvantaged populations (e.g., loans to underrepresented groups)– Follows legislative procedures, such as those associated with IDEA and Medicare– Follows social customs for greeting
RITUALS —Rituals are shared social actions with traditional, emotional, purposive, and technological meaning, contributing to values and beliefs within the population.	<ul style="list-style-type: none">– Holds cultural celebrations– Has parades or demonstrations– Shows national affiliations/allegiances– Follows religious, spiritual, and cultural practices, such as touching the mezuzah or using holy water when leaving/entering, praying to Mecca
ROLES	<ul style="list-style-type: none">– SEE DESCRIPTION OF THESE AREAS FOR INDIVIDUALS WITHIN THE POPULATION

Note. In this document, habits are addressed only in Table 5A (Person).

TABLE 6. CONTEXTS AND ENVIRONMENTS

Context and *environment* (including cultural, personal, temporal, virtual, physical, and social) refers to a variety of interrelated conditions within and surrounding the client that influence performance.

The term *context* refers to a variety of interrelated conditions that are within and surrounding the client. Contexts include cultural, personal, temporal, and virtual. The term *environment* refers to the external physical and social environments that surround the client and in which the client's daily life occupations occur.

Context and Environment	Definition	Examples
Cultural	Customs, beliefs, activity patterns, behavior standards, and expectations accepted by the society of which the client is a member. Includes ethnicity and values as well as political aspects, such as laws that affect access to resources and affirm personal rights. Also includes opportunities for education, employment, and economic support.	<i>Person:</i> Shaking hands when being introduced <i>Organization:</i> Employees marking the end of the work week with casual dress on Friday <i>Population:</i> Celebrating Independence Day
Personal	"[F]eatures of the individual that are not part of a health condition or health status" (WHO, 2001, p. 17). Personal context includes age, gender, socioeconomic status, and educational status. Can also include organizational levels (e.g., volunteers and employees) and population levels (e.g., members of society).	<i>Person:</i> Twenty-five-year-old unemployed man with a high school diploma <i>Organization:</i> Volunteers working in a homeless shelter <i>Population:</i> Teenage women who are pregnant or new mothers
Temporal	"Location of occupational performance in time" (Neistadt & Crepeau, 1998, p. 292). The experience of time as shaped by engagement in occupations. The temporal aspects of occupation "which contribute to the patterns of daily occupations" are "the rhythm...tempo...synchronization...duration...and sequence" (Larson & Zemke, 2004, p. 82; Zemke, 2004, p. 610). Includes stages of life, time of day or year, duration, rhythm of activity, or history.	<i>Person:</i> A person retired from work for 10 years <i>Organization:</i> Annual fundraising campaign <i>Population:</i> Engaging in siestas or high teas
Virtual	Environment in which communication occurs by means of airways or computers and an absence of physical contact. Includes simulated or real-time or near-time existence of an environment via chat rooms, email, video-conferencing, radio transmissions.	<i>Person:</i> Text message to a friend <i>Organization:</i> Video conference, telephone conference call, instant message, interactive white boards among all the members <i>Population:</i> Virtual community of gamers
Physical	Natural and built nonhuman environment and the objects in them: <ul style="list-style-type: none"> • Natural environment includes geographic terrain, sensory qualities of environment, plants and animals • Built environment and objects includes buildings, furniture, tools or devices. 	<i>Person:</i> Individual's house, apartment <i>Organization:</i> Office building, factory <i>Population:</i> Transportation system
Social	Is constructed by presence, relationships, and expectations of persons, organizations, populations. <ul style="list-style-type: none"> • Availability and expectations of significant individuals, such as spouse, friends, and caregivers • Relationships with individuals, groups, or organizations • Relationships with systems (e.g., political, legal, economic, institutional) that are influential in establishing norms, role expectations, and social routines. 	<i>Person:</i> Friends, colleagues <i>Organization:</i> Advisory board <i>Population:</i> City government

EVALUATION

Occupational profile—The initial step in the evaluation process that provides an understanding of the client's occupational history and experiences, patterns of daily living, interests, values, and needs. The client's problems and concerns about performing occupations and daily life activities are identified, and the client's priorities are determined.

Analysis of occupational performance—The step in the evaluation process during which the client's assets, problems, or potential problems are more specifically identified. Actual performance is often observed in context to identify what supports performance and what hinders performance. Performance skills, performance patterns, context or contexts, activity demands, and client factors are all considered, but only selected aspects may be specifically assessed. Targeted outcomes are identified.

INTERVENTION

Intervention plan—A plan that will guide actions taken and that is developed in collaboration with the client. It is based on selected theories, frames of reference, and evidence. Outcomes to be targeted are confirmed.

Intervention implementation—Ongoing actions taken to influence and support improved client performance. Interventions are directed at identified outcomes. Client's response is monitored and documented.

Intervention review—A review of the implementation plan and process as well as its progress toward targeted outcomes.

OUTCOMES (*Supporting Health and Participation in Life Through Engagement in Occupation*)

Outcomes—Determination of success in reaching desired targeted outcomes. Outcome assessment information is used to plan future actions with the client and to evaluate the service program (i.e., program evaluation).

Figure 5. Process of Service Delivery.

The process of service delivery is applied within the profession's domain to support the client's health and participation.

ations absent of physical contact. Some contexts are external to the client (e.g., virtual), some are internal to the client (e.g., personal), and some may have both external features and internalized beliefs and values (e.g., cultural).

Clients' engagement in occupations evolves within their social and physical environments and reflects their interdependence with these environments. Cultural contexts often influence how occupations are chosen, prioritized, and organized. Contexts and environments affect a client's accessibility to occupations and influence the quality of performance and satisfaction with performance. A client who has difficulty performing effectively in one environment or context may be successful when the environment or context is changed. The context within which the engagement in occupations occurs is unique for each client. Contexts and environments are interrelated both with each other and all other aspects of the domain (see Table 6 for a description of the different kinds of contexts and environments).

Process of Occupational Therapy

Overview

This second section of the *Occupational Therapy Practice Framework* describes the process that outlines the way in which occupational therapy practitioners operationalize their expertise to provide services to clients (see Figure 5). This process includes evaluation, intervention, and outcome monitoring; occurs within the purview of the domain; and involves collaboration among the occupational therapist, occupational therapy assistant, and the client. Occupational therapy practitioners are required to maintain appropriate credentials and abide by ethical standards, existing laws, and regulatory requirements for each step of the occupational therapy process.

Many professions use the process of evaluating, intervening, and targeting intervention **outcomes**. However, only occupational therapy practitioners focus this process toward the end-goal of supporting health and participation in life through engage-

ment in occupations. Occupational therapy practitioners also use occupations as a method of intervention implementation by engaging clients throughout the process in occupations that are therapeutically selected. The profession's use of occupation as both means and end is a unique application of the process (Trombly, 1995).

Although for the purpose of organization the *Framework* describes the process in a linear manner, in reality, the process does not occur in a sequenced, step-by-step fashion (see Table 7). Instead, it is fluid and dynamic, allowing occupational therapy practitioners to operate with an ongoing focus on outcomes while continually reflecting on and changing an overall plan to accommodate new developments and insights along the way.

Occupational therapy involves facilitating interactions among the client, the environments or contexts, and the activities or occupations in order to help the client reach the desired outcomes that support health and participation in life. Occupational therapy practitioners apply theory, evidence, knowledge, and skills regarding the therapeutic use of occupations to positively affect the client's health, well-being, and life satisfaction.

The broader definition of *client* included in this document is indicative of the profession's increasing involvement in providing services not only to a person but also to organizations and populations. Regardless of whether the client is a person, organization, or population, the client's wants, needs, occupational risks, and problems are evaluated, and information is gathered, synthesized, and framed from an occupational perspective. This perspective is based on the theories, knowledge, and skills generated and used by the profession and informed by available evidence. Client concerns are viewed relative to problems or risks in occupational performance.

Occupational therapy practitioners develop a collaborative relationship with clients in order to understand their experiences and desires for intervention, as noted in Figure 2. The collaborative approach, which is used throughout the process, honors the contributions of the client and the occupational therapy practitioner. Clients bring knowledge about their life experiences and their **hopes** and dreams for the future. They identify and share their needs and priorities. Occupational therapy practitioners bring their knowledge about how engagement in occupation affects health and performance. This information is coupled with the practitioner's **clinical reasoning** and theoretical perspectives to critically observe, analyze, describe, and interpret human performance. Occupational therapy practitioners also apply knowledge and skills to reduce the effects of disease, disability, and deprivation and to promote health and well-being. Together, practitioners and clients identify and prioritize the focus of the intervention plan. This collaboration may include family, significant others, community members, and stakeholders who affect or are affected by the client's engagement in occupation, health, and participation.

Rarely is an individual the exclusive focus of the intervention. For example, the needs of an at-risk infant may be the initial impetus for intervention, but the concerns and priorities of the parent, the extended family, and funding agencies also are considered. Similarly, services addressing independent-living skills for adults coping with serious and persistent mental illness may involve the needs and expectations of state and local services agencies as well as business groups.

Throughout the process, the occupational therapy practitioner is engaged continually in clinical reasoning about the client's engagement in occupation. Clinical reasoning enables the occupational therapy practitioner to (1) identify

TABLE 7. OPERATIONALIZING THE OCCUPATIONAL THERAPY PROCESS

Evaluation		Intervention			Outcomes
<i>Occupational Profile</i>	<i>Analysis of Occupational Performance</i>	<i>Intervention Plan</i>	<i>Intervention Implementation</i>	<i>Intervention Review</i>	<i>Supporting Health and Participation in Life through Engagement in Occupation</i>
<p>Identify</p> <ul style="list-style-type: none"> • Who is the client? • Why is the client seeking services? • What occupations and activities are successful or are causing problems? • What contexts and environments support or inhibit desired outcomes? • What is the client's occupational history? • What are the client's priorities and targeted outcomes? 	<ul style="list-style-type: none"> • Synthesize information from the occupational profile. • Observe client's performance in desired occupation/activity. • Note the effectiveness of performance skills and patterns and select assessments to identify factors (context or contexts, activity demands, client factors) that may be influencing performance skills and patterns. • Interpret assessment data to identify facilitators and barriers to performance. • Develop and refine hypotheses about client's occupational performance strengths and weaknesses. • Collaborate with client to create goals that address targeted outcomes. • Delineate areas for intervention based on best practice and evidence. 	<ul style="list-style-type: none"> • Develop plan that includes <ul style="list-style-type: none"> –Objective and measurable goals with time frame, –Occupational therapy intervention approach based on theory and evidence, and –Mechanisms for service delivery. • Consider discharge needs and plan. • Select outcome measures. • Make recommendation or referral to others as needed. 	<ul style="list-style-type: none"> • Determine types of occupational therapy interventions to be used and carry them out. • Monitor client's response according to ongoing assessment and reassessment. 	<ul style="list-style-type: none"> • Reevaluate plan relative to achieving targeted outcomes. • Modify plan as needed. • Determine need for continuation, discontinuation, or referral. 	<ul style="list-style-type: none"> • Focus on outcomes as they relate to supporting health and participation in life through engagement in occupation. • Select outcome measures. • Measure and use outcomes.
		<p>←———— Continue to renegotiate intervention plans and targeted outcomes. —————→</p>			
<p>←———— Ongoing interaction among evaluation, intervention, and outcomes occurs throughout the process. —————→</p>					

the multiple demands, skills, and potential meanings of the activity and (2) gain a deeper understanding of the interrelationships between aspects of the domain that affect performance and those that will support client-centered interventions and outcomes.

Evaluation

The **evaluation** process begins with an evaluation conducted by the occupational therapist and is focused on finding out what the client wants and needs to do, determining what the client can do and has done, and identifying those factors that act as supports or barriers to health and participation. Evaluation often occurs both formally and informally during all interactions with the client. The type and focus of the evaluation differs depending on the practice setting.

The evaluation consists of the **occupational profile** and **analysis of occupational performance**. The *occupational profile* includes information about the client and the client's needs, problems, and concerns about performance in areas of occupation. The *analysis of occupational performance* focuses on collecting and interpreting information using **assessment** tools designed to observe, measure, and inquire about factors that support or hinder occupational performance. Although the ways occupational therapists collect client information are described separately and sequentially in the *Framework*, the exact manner is influenced by the client needs and the practice setting. Information related to the occupational profile is gathered throughout the occupational therapy process.

The occupational therapist's knowledge and skills, as well as theoretical principles and available evidence, guide his or her clinical reasoning for the selection and application of various theories and frames of reference throughout the evaluation process. Concurrently, the occupational therapist's

knowledge and skills in these areas influence the information that is collected during the evaluation. Knowledge and evidence about occupational performance problems and diagnostic conditions are used to guide information gathering and synthesis of information for interpretation and intervention planning. The occupational therapist's skilled interpretation of assessment results relative to the whole evaluation leads to a clear delineation of the strengths and limitations affecting the client's occupational performance. The occupational therapy assistant contributes to the evaluation process based on established competencies and under the supervision of an occupational therapist.

Occupational Profile

An *occupational profile* is defined as a summary of information that describes the client's occupational history and experiences, patterns of daily living, **interests**, values, and needs. Because the profile is designed to gain an understanding of the client's perspective and background, its format varies depending on whether the client is a person, organization, or population. Using a **client-centered approach**, the occupational therapy practitioner gathers information to understand what is currently important and meaningful to the client. The profile includes inquiry related to what the client wants and needs to do in the present or future as well as past experiences and interests that may assist in identifying strengths and limitations. Refinement of the information collected during the occupational profile subsequently refines the intervention plan and identified outcomes.

During the process of collecting this information, the client's priorities and desired outcomes that will lead to engagement in occupation for improved health are identified. Clients identify occupations that give meaning to their lives and select the **goals** and priorities important to them. Valuing and respecting the client's collaboration in

the therapeutic process helps foster client involvement and more efficiently guide interventions.

The process and timing of completing the occupational profile varies depending on the circumstances. Occupational therapy practitioners may gather information formally and informally in one session or over a longer period while working with the client. Obtaining information through both formal interview and casual conversation helps establish a therapeutic relationship with the client. Ideally, the information obtained during the development of the occupational profile leads to a more client-centered approach in the evaluation, intervention planning, and intervention implementation stages.

Specifically, the information collected answers the following questions:

- Who is the client (person, including family, caregivers, and significant others; population; or organization)?
- Why is the client seeking services, and what are the client's current concerns relative to engaging in occupations and in daily life activities?
- What areas of occupation are successful, and what areas are causing problems or risks (see Table 1)?
- What contexts and environments support or inhibit participation and engagement in desired occupations?
- What is the client's occupational history (i.e., life experiences, values, interests, previous patterns of engagement in occupations and in daily life activities, the meanings associated with them)?
- What are the client's priorities and desired outcomes?

Once the profile data are collected and documented, the occupational therapist reviews the information; identifies the client's strengths, limitations, and needs; and develops a working hypothe-

sis regarding possible reasons for identified problems and concerns. The occupational therapy assistant contributes to this process. The information from the occupational therapy profile often guides the selection of outcome measures. If an organization or population is the identified client, the strengths and needs are those that affect the collective entity rather than the individual.

Analysis of Occupational Performance

Occupational performance is the accomplishment of the selected occupation resulting from the dynamic transaction among the client, the context and environment, and the activity. Evaluation of occupational performance involves one or more of the following:

- Synthesizing information from the occupational profile to focus on specific areas of occupation and contexts that need to be addressed;
- Observing the client's performance during activities relevant to desired occupations, noting effectiveness of the performance skills and performance patterns;
- Selecting and using specific assessments to measure performance skills and performance patterns, as appropriate;
- Selecting assessments, as needed, to identify and measure more specifically contexts or environments, activity demands, and client factors influencing performance skills and performance patterns;
- Interpreting the assessment data to identify what supports performance and what hinders performance;
- Developing and refining hypotheses about the client's occupational performance strengths and limitations;
- Creating goals in collaboration with the client that address the desired outcomes;
- Determining procedures to measure the outcomes of intervention; and

- Delineating a potential intervention approach or approaches based on best practices and available evidence.

Multiple methods often are used during the evaluation process to assess the client, the context, the occupation or activity, and the occupational performance. Methods may include an interview with the client and significant others, observation of performance and context, record review, and direct assessment of specific aspects of performance. Formal and informal, structured and unstructured, and standardized criterion or norm-referenced assessment tools can be used. Standardized assessments are preferred, when appropriate, to provide objective data about the various aspects of the domain influencing engagement and performance. “Obtaining reliable and valid information [through the use of standard assessments] provides a high level of support that can justify the need for occupational therapy services” (Gutman, Mortera, Hinojosa, & Kramer, 2007, p. 121).

Activity analysis is an important process used by occupational therapy practitioners to understand the demands that a specific desired activity places on a client. “Activity analysis addresses the typical demands of an activity, the range of skills involved in its performance, and the various cultural meanings that might be ascribed to it” (Crepeau, 2003, p. 192). When activity analysis is completed and the demands of a specific activity that the client wants and needs to do are understood, the client’s specific skills and abilities are then compared with the selected activity’s demands.

Occupation-based activity analysis places the person [client] in the foreground. It takes into account the particular person’s [client’s] interests, goals, abilities, and contexts, as well as the demands of the activity itself. These considerations shape the practitioner’s efforts to help the...person [client] reach his/her goals through carefully designed evaluation and intervention. (Crepeau, 2003, p. 193)

Examining the environments and contexts in which occupational performance can or does occur provides insights into overarching, underlying, and embedded influences on engagement. The external environments and context (e.g., physical and social environment, virtual context) provide resources that support or inhibit the client’s performance (e.g., doorway widths as part of the physical environment that allow for wheelchair passage, presence or absence of a caregiver as part of the social environment, access to a computer to communicate with others as part of the virtual context). Different environments (e.g., community, institution, home) provide different supports and resources for service delivery (e.g., assessment of an infant or toddler in the hospital without the primary caregivers present yields different results than while at home with a parent).

The client’s personal context affects service delivery by influencing personal beliefs, perceptions, and expectations. The cultural context exists within small groups of related individuals, such as a nuclear family, and within larger groups of people, such as populations of a country or ethnic group. The expectations, beliefs, and customs of various cultures can affect a client’s **identity** and activity choices and need to be considered when determining how and when services may be delivered. Note that in Figure 2, context and environment are depicted as surrounding and underlying the process.

Analyzing occupational performance requires an understanding of the complex and dynamic interaction among performance skills, performance patterns, contexts and environments, activity demands, and client factors. Occupational therapy practitioners attend to each aspect and gauge the influence of each aspect on the others—individually and collectively. By understanding how these aspects dynamically influence each other, occupational therapists can better evaluate how they contribute to the client’s performance-related concerns, and how they

“Supporting health and participation in life through engagement in occupation is the broad, overarching outcome of the occupational therapy intervention process.”

potentially contribute to interventions that support occupational performance. When working with an organization or population, occupational therapy practitioners consider the collective occupational performance abilities of the respective members.

Intervention

The **intervention** process consists of the skilled actions taken by occupational therapy practitioners in collaboration with the client to facilitate engagement in occupation related to health and participation. Occupational therapy practitioners use the information about the client gathered during the evaluation and from theoretical principles to direct occupation-centered interventions. Intervention is provided then to assist the client in reaching a state of physical, mental, and social well-being; to identify and realize aspirations; to satisfy needs; and to change or cope with the environment. A variety of types of occupational therapy interventions are discussed in Table 8.

Intervention is intended to be health-promoting. *Health promotion* is “the process of enabling people to increase control over, and to improve, their health” (WHO, 1986). Wilcock (2006) states

[F]ollowing an occupation-focused health promotion approach to well-being embraces a belief that the potential range of what people can do, be, and strive to become is the primary concern and that health is a by-product. A varied and full occupational lifestyle will coincidentally maintain and improve health and well-being if it enables people to be creative and adventurous physically, mentally, and socially. (p. 315)

Interventions vary depending on the client—person, organization, or population—and the context of service delivery (Moyers & Dale, 2007). The actual term used for clients receiving occupational therapy varies among practice settings and delivery models. For example, when working in a hospital, the person might be referred to as a *patient*, and in a school, the client might be a *student, teacher, parent, or administrator*. When providing services to an organization, the client may be called the *consumer*. When serving a population, the client may be specific entities, such as disability groups, veterans who are homeless, or refugees.

The term *person* includes others who also may help or be served indirectly, such as caregiver, teacher, parent, employer, or spouse. When addressing the person or a small group of persons who support or care for the client in need of services (e.g., caregiver, teacher, partner, employer, spouse), the practitioners address the interaction among client factors, performance skills, performance patterns, contexts and environments, and activity demands that influence occupational performance within those occupations the person needs and wants to do. The intervention focus is on modifying the environment/contexts and activity demands or patterns, promoting health, establishing or restoring and maintaining occupational performance, and preventing further disability and occupational performance problems.

Interventions provided to *organizations* are designed to affect the organization to more efficiently and effectively meet the needs of the clients or

TABLE 8. TYPES OF OCCUPATIONAL THERAPY INTERVENTIONS

THERAPEUTIC USE OF SELF—An occupational therapy practitioner's planned use of his or her personality, insights, perceptions, and judgments as part of the therapeutic process (adapted from Punwar & Peloquin, 2000, p. 285).

THERAPEUTIC USE OF OCCUPATIONS AND ACTIVITIES^a—Occupations and activities selected for specific clients that meet therapeutic goals. To use occupations/activities therapeutically, context or contexts, activity demands, and client factors all should be considered in relation to the client's therapeutic goals. Use of assistive technologies, application of universal-design principles, and environmental modifications support the ability of clients to engage in their occupations.

Occupation-based intervention

Purpose: Client engages in client-directed occupations that match identified goals.

Examples:

- Completes morning dressing and hygiene using adaptive devices
- Purchases groceries and prepares a meal
- Utilizes the transportation system
- Applies for a job
- Plays on playground and community recreation equipment
- Participates in a community festival
- Establishes a pattern of self-care and relaxation activities in preparation for sleep

Purposeful activity

Purpose: Client engages in specifically selected activities that allow the client to develop skills that enhance occupational engagement.

Examples:

- Practices how to select clothing and manipulate clothing fasteners
- Practices safe ways to get in and out of a bathtub
- Practices how to prepare a food list and rehearses how to use cooking appliances
- Practices how to use a map and transportation schedule
- Rehearses how to write answers on an application form
- Practices how to get on and off playground and recreation equipment
- Role plays when to greet people and initiates conversation
- Practices how to use adaptive switches to operate home environmental control system

Preparatory methods

Purpose: Practitioner selects directed methods and techniques that prepare the client for occupational performance. Used in preparation for or concurrently with purposeful and occupation-based activities.

Examples:

- Provides sensory enrichment to promote alertness
- Administers physical agent modalities to prepare muscles for movement
- Provides instruction in visual imagery and rhythmic breathing to promote rest and relaxation
- Issues orthotics/splints to provide support and facilitate movement
- Suggests a home-based conditioning regimen using Pilates and yoga
- Provides hand-strengthening exercises using therapy putty and theraband
- Provides instruction in assertiveness to prepare for self-advocacy

(Continued)

TABLE 8. TYPES OF OCCUPATIONAL THERAPY INTERVENTIONS*(Continued)*

CONSULTATION PROCESS—A type of intervention in which occupational therapy practitioners use their knowledge and expertise to collaborate with the client. The collaborative process involves identifying the problem, creating possible solutions, trying solutions, and altering them as necessary for greater effectiveness. When providing consultation, the practitioner is not directly responsible for the outcome of the intervention (Dunn, 2000a, p. 113).

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|---------------|--|
| Person | <ul style="list-style-type: none"> • Advises a family about architectural options • Advises family how to create pre-sleep nighttime routines for their children |
|---------------|--|
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|---------------------|--|
| Organization | <ul style="list-style-type: none"> • Recommends work pattern modifications and ergonomically designed workstations for a company • Recommends disaster evacuation strategies for a residential community related to accessibility and reduced environmental barriers |
|---------------------|--|
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|-------------------|---|
| Population | <ul style="list-style-type: none"> • Advises senior citizens on older driver initiatives |
|-------------------|---|
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EDUCATION PROCESS—An intervention process that involves imparting knowledge and information about occupation, health, and participation and that does not result in the actual performance of the occupation/activity.

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|---------------|--|
| Person | <ul style="list-style-type: none"> • Instructs a classroom teacher on sensory regulation strategies |
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|---------------------|---|
| Organization | <ul style="list-style-type: none"> • Teaches staff at a homeless shelter how to structure daily living, play, and leisure activities for shelter members |
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|-------------------|---|
| Population | <ul style="list-style-type: none"> • Instructs town officials about the value of and strategies for making walking and biking paths accessible for all community members |
|-------------------|---|
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ADVOCACY—Efforts directed toward promoting occupational justice and empowering clients to seek and obtain resources to fully participate in their daily life occupations.

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|---------------|---|
| Person | <ul style="list-style-type: none"> • Collaborates with a person to procure reasonable accommodations at worksite |
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| Organization | <ul style="list-style-type: none"> • Serves on policy board of an organization to procure supportive housing accommodations for persons with disabilities |
|---------------------|--|
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|-------------------|--|
| Population | <ul style="list-style-type: none"> • Collaborates with adults with serious mental illness to raise public awareness of the impact of this stigma • Collaborates with and educates federal funding sources for the disabled population to include cancer patients prior to their full remission |
|-------------------|--|
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^aInformation adapted from Pedretti and Early (2001).

consumers and stakeholders. Practitioners address features of the organization or agency such as its mission, values, organizational culture and structure, policies and procedures, and built and natural environments. Practitioners evaluate how each of these features either supports or inhibits the overall performance of individuals within the organization. For example, to enable the staff at a skilled-nursing facility to provide better services, an occupational therapy practitioner may recommend the walls in each hallway be painted a different color, enabling residents to more easily locate their rooms.

Interventions provided to *populations* are directed to all the members of the group collectively rather than individualized to specific people within the group. Practitioners direct their interventions toward current or potential health problems and disabling conditions within the population and community. Their goal is to enhance the health of all people within the population by addressing services and supports within the community that can be implemented to improve the population's performance. The intervention focus often is on health promotion activities, self-management educational services, and environmental modification. For instance, the occupational therapy practitioner may design developmentally based day care programs run by college student volunteers for homeless shelters catering to families in a large metropolitan area. Practitioners may work with a wide variety of populations experiencing difficulty in accessing and engaging in health occupations due to conditions such as poverty, homelessness, and discrimination.

The intervention process is divided into three steps: (1) intervention plan, (2) intervention implementation, and (3) intervention review. During the intervention process, information from the evaluation is integrated with theory, practice models, frames of reference, and evidence. This information guides the clinical reasoning of the occupa-

tional therapist and the occupational therapy assistant in the development, implementation, and review of the intervention plan.

Intervention Plan

The intervention plan directs the actions of the occupational therapist and occupational therapy assistant. It describes the selected occupational therapy approaches and types of interventions for reaching the client's identified outcomes. The intervention plan is developed collaboratively with the client and is based on the client's goals and priorities. Depending on whether the client is a person, organization, or population, others such as family members, significant others, board members, service providers, and community groups also may collaborate in the development of the plan.

The design of the intervention plan is directed by the

- Client's goals, values, beliefs, and occupational needs;
- Client's health and well-being;
- Client's performance skills and performance patterns;
- Collective influence of the context, environment, activity demands, and client factors on the client;
- Context of service delivery in which the intervention is provided (e.g., caregiver expectations, organization's purpose, payer's requirements, applicable regulations); and
- Best available evidence.

The selection and design of the intervention plan and goals are directed toward addressing the client's current and potential problems related to engagement in occupations or activities.

Intervention planning includes the following steps:

1. *Developing the plan.* The occupational therapist develops the plan with the client, and the

occupational therapy assistant contributes to the plan's development. The plan includes

- Objective and measurable goals with a time-frame
- Occupational therapy **intervention approach** or approaches (see Table 9)
 - Create or promote
 - Establish or restore
 - Maintain
 - Modify
 - Prevent.
- Mechanisms for service delivery
 - People providing the intervention
 - Types of interventions
 - Frequency and duration of service.

2. *Considering potential discharge needs and plans*
3. *Selecting outcome measures*
4. *Making recommendation or referral to others as needed.*

Intervention Implementation

Intervention implementation is the process of putting the plan into action. It involves the skilled process of altering factors in the client, activity, and context and environment for the purpose of effecting positive change in the client's desired engagement in occupation, health, and participation.

Interventions may focus on a single aspect of the domain, such as a specific performance pattern, or several aspects of the domain, such as performance patterns, performance skills, and context. Given that the factors are interrelated and influence one another in a continuous, dynamic process, occupational therapy practitioners expect that the client's ability to adapt, change, and develop in one area will affect other areas. Because of this dynamic interrelationship, assessment and intervention planning continue throughout the implementation process. Intervention implementation includes the following steps:

1. Determining and carrying out the type of occupational therapy intervention or interventions to be used (see Table 8)
 - Therapeutic use of self
 - Therapeutic use of occupations or activities
 - **Occupation-based interventions**
 - **Purposeful activity**
 - **Preparatory methods.**
 - **Consultation process**
 - **Education process**
 - **Advocacy.**
2. Monitoring the client's response to interventions based on ongoing assessment and reassessment of the client's progress toward goals.

Intervention Review

Intervention review is the continuous process of reevaluating and reviewing the intervention plan, the effectiveness of its delivery, and the progress toward outcomes. As during intervention planning, this process includes collaboration with the client based on his or her goals. Depending on whether the client is a person, organization, or population, various stakeholders, such as family members, significant others, board members, other service providers, and community groups, also may collaborate in the intervention review. **Re-evaluation** and review may lead to change in the intervention plan.

The intervention review includes the following steps:

1. Re-evaluating the plan and how it is implemented relative to achieving outcomes
2. Modifying the plan as needed
3. Determining the need for continuation or discontinuation of occupational therapy services and for referral to other services.

The intervention review may include program evaluations that critique the way that occupational therapy services are provided. This may include a review of client satisfaction and the client's perception of the benefits of receiving occupational ther-

TABLE 9. OCCUPATIONAL THERAPY INTERVENTION APPROACHES

Specific strategies selected to direct the process of intervention that are based on the client's desired outcome, evaluation data, and evidence.

Approach	Focus of Intervention	Examples
Create, promote (health promotion)^a —An intervention approach that does not assume a disability is present or that any factors would interfere with performance. This approach is designed to provide enriched contextual and activity experiences that will enhance performance for all persons in the natural contexts of life (adapted from Dunn, McClain, Brown, & Youngstrom, 1998, p. 534).	Performance skills	<ul style="list-style-type: none"> • Create a parenting class to help first-time parents engage their children in developmentally appropriate play
	Performance patterns	<ul style="list-style-type: none"> • Promote effective handling of stress by creating time use routines with healthy clients
	Context or contexts or physical environments	<ul style="list-style-type: none"> • Promote a diversity of sensory play experiences by recommending a variety of equipment for playgrounds and other play areas
	Activity demands	<ul style="list-style-type: none"> • Serve food family style in the congregate dining area to increase the opportunities for socialization
Establish, restore (remediation, restoration)^a —An intervention approach designed to change client variables to establish a skill or ability that has not yet developed or to restore a skill or ability that has been impaired (adapted from Dunn et al., 1998, p. 533).	Client factors (body functions, body structures)	<ul style="list-style-type: none"> • Promote increased endurance by recommending year-round daily outdoor recess for all school children • Design a dance program for senior citizens that will enhance strength and flexibility
	Performance skills	<ul style="list-style-type: none"> • Provide adjustable desk chairs to improve client sitting posture • Work with senior community centers to offer driving educational programs targeted at improving driving skills for persons ages 65 or older
	Performance patterns	<ul style="list-style-type: none"> • Collaborate with clients to help them establish morning routines needed to arrive at school or work on time • Provide classes in fatigue management for cancer patients and their families • Collaborate with clients to help them establish healthy sleep–wake patterns • Develop walking programs at the local mall for employees and community members
	Client factors (body functions, body structures)	<ul style="list-style-type: none"> • Support daily physical education classes for entire population of children in a school aimed at improving physical strength and endurance • Collaborate with schools and businesses to establish universal-design models in their buildings, classrooms, and so forth • Gradually increase time required to complete a computer game to increase client's attention span

(Continued)

TABLE 9. OCCUPATIONAL THERAPY INTERVENTION APPROACHES*(Continued)*

Approach	Focus of Intervention	Examples
<p>Maintain—An intervention approach designed to provide the supports that will allow clients to preserve the performance capabilities they have regained, that continue to meet their occupational needs, or both. The assumption is that, without continued maintenance intervention, performance would decrease, occupational needs would not be met, or both, thereby affecting health and quality of life.</p>	Performance skills	<ul style="list-style-type: none"> • Maintain the ability of the client to organize tools by providing a tool outline painted on a pegboard • Develop a refresher safety program for industrial organizations to remind workers of need to continue to use safety skills on the job • Provide a program for community-dwelling older adults to maintain motor and praxis skills
	Performance patterns	<ul style="list-style-type: none"> • Enable client to maintain appropriate medication schedule by providing a timer to aid with memory • Establish occupational performance patterns to maintain a healthy lifestyle after significant weight loss
	Context or contexts or physical environments	<ul style="list-style-type: none"> • Maintain safe and independent access for persons with low vision by recommending increased hallway lighting • During a natural disaster, work with facilities identified as “shelters” to provide play and leisure activities for displaced people to allow a constructive outlet and semblance of normalcy • Incorporate principles of universal design in homes to allow people to age in place
	Activity demands	<ul style="list-style-type: none"> • Maintain independent gardening for persons with arthritic hands by recommending tools with modified grips, long-handled tools, seating alternatives, raised gardens, and so forth
	Client factors (body functions, body structures)	<ul style="list-style-type: none"> • Provide multisensory activities in which nursing-home residents may participate to maintain alertness • Provide hand-based thumb splint for client use during periods of stressful or prolonged intensive activity to maintain pain-free joints
<p>Modify (compensation, adaptation)^a—An intervention approach directed at “finding ways to revise the current context or activity demands to support performance in the natural setting, [including] compensatory techniques, [such as]...enhancing some features to provide cues or reducing other features to reduce distractibility” (Dunn et al., 1998, p. 533).</p>	Performance patterns	<ul style="list-style-type: none"> • Provide a visual schedule to help a student follow routines and transition easily between activities at home and school • Simplify task sequence to help a person with cognitive issues complete a morning self-care routine
	Context or contexts or physical environments	<ul style="list-style-type: none"> • Assist a family in determining requirements for building a ramp at home for a family member who is returning home after physical rehabilitation • Consult with builders in designing homes that will allow families the ability to provide living space for aging parents (e.g., bedroom and full bath on the main floor of a multilevel dwelling) • Modify the number of people in a room to decrease client’s distractibility

TABLE 9. OCCUPATIONAL THERAPY INTERVENTION APPROACHES*(Continued)*

Approach	Focus of Intervention	Examples
<p>Prevent (disability prevention)^a—An intervention approach designed to address clients with or without a disability who are at risk for occupational performance problems. This approach is designed to prevent the occurrence or evolution of barriers to performance in context. Interventions may be directed at client, context, or activity variables (adapted from Dunn et al., 1998, p. 534).</p>	Activity demands	<ul style="list-style-type: none"> • Adapt writing surface used in classroom by fourth grader by adding adjustable incline board • Assist a patient with a terminal illness and his or her family in modifying tasks to maintain engagement • Consult with school teams on placement of switches to increase students' access to computers, augmentative communication devices, environmental devices, and so forth • Provide a seat at the assembly station to allow a client with decreased standing tolerance to be able to continue to perform
	Performance skills	<ul style="list-style-type: none"> • Prevent poor posture when sitting for prolonged periods by providing a chair with proper back support
	Performance patterns	<ul style="list-style-type: none"> • Aid in the prevention of illicit chemical substance use by introducing self-initiated routine strategies that support drug-free behavior
	Context or contexts or physical environments	<ul style="list-style-type: none"> • Prevent social isolation of employees by promoting participation in after-work group activities • Reduce risk of falls by modifying the environment and removing known hazards in the home (e.g., throw rugs)
	Activity demands	<ul style="list-style-type: none"> • Prevent back injury by providing instruction in proper lifting techniques
Client factors (body functions, body structures)	<ul style="list-style-type: none"> • Prevent repetitive stress injury by suggesting that clients wear a wrist support splint when typing • Consultation with hotel chain to provide an ergonomics educational program designed to prevent back injuries in housekeepers 	

^aParallel language used in Moyers and Dale (2007, p. 34).

apy services (adapted from Maciejewski, Kawiecki, & Rockwood, 1997). Examples may include (1) a letter of thanks from the family of a child with spinal bifida (person); (2) a request for additional occupational therapy services at a homeless shelter for their clients (organizations); and (3) procurement of funds to implement support groups for caregivers of people with Alzheimer's disease throughout the United States (populations).

Outcomes

Supporting health and participation in life through engagement in occupation is the broad, overarching outcome of the occupational therapy intervention process. This outcome statement acknowledges the profession's belief that active engagement in occupation promotes, facilitates, and maintains health and participation. *Outcomes* are defined as important dimensions of health, attributed to interventions, and include the ability to function, health perceptions, and satisfaction with care (adapted from Request for Planning Ideas, 2001). Outcomes are the end-result of the occupational therapy process and describe what occupational therapy intervention can achieve with clients.

The three interrelated concepts included in the profession's overarching outcome are defined as

1. *Health*—"[A] positive concept emphasizing social and personal resources, as well as physical capacities" (WHO, 1986).
2. *Participation*—That is, "involvement in a life situation" (WHO, 2001, p. 10). Participation naturally occurs when clients are actively involved in carrying out occupations or daily life activities they find purposeful and meaningful in desired contexts. More specific outcomes of occupational therapy intervention (see Table 10) are multidimensional and support the end-result of participation.
3. *Engagement in occupation*—The commitment made to performance in occupations as the

result of choice, motivation, and meaning and includes objective and subjective aspects of carrying out activities meaningful and purposeful to the individual person, organization, or population. Occupational therapy intervention focuses on creating or facilitating opportunities to engage in these occupations.

To determine the client's success in achieving health and participation in life through engagement in occupation, occupational therapy practitioners assess observable outcomes. This assessment takes into consideration the hypothesized relationships among various aspects of occupational performance. For example, a client's improved ability to embed performance skills into a routine (performance pattern) and improved strength or range of motion (body functions) enables engagement in managing a home (IADL).

Implicit in any outcome assessment used by occupational therapy practitioners are the client's beliefs systems and underlying assumptions regarding their desired occupational performance. The assessment tools and the variables measured often become the operational definition for the outcome. Therefore, occupational therapy practitioners select outcome assessments pertinent to the needs and desires of clients, congruent with the practitioner's theoretical model of practice, based on knowledge of the psychometric properties of standardized measures or the rationale and protocols of non-standardized measures and the available evidence. In addition, the client's perception of success in engaging in desired occupations is vital to any outcomes assessment. As a point of comparison and in collaboration with the client, the occupational therapist may revisit the occupational profile to assess change.

The benefits of occupational therapy are multifaceted and may occur in all aspects of the domain of concern. Supporting health and participation in life through engagement in occupation is the broad outcome of intervention. Clients' improved perfor-

mance of occupations, perceived happiness, self-efficacy, and hopefulness about their life and abilities are valuable outcomes. For example, parents whose children received occupational therapy valued understanding their child's behaviors in new ways and had greater perceived efficacy about their parenting (Cohn, 2001; Cohn, Miller, & Tickle-Degnan, 2000). Interventions designed for caregivers who provide care for people with dementia improve the quality of life for both the care recipient and the caregiver. Caregivers who received intervention reported fewer declines in the occupational performance of care recipients and less need for help and enhanced mastery and skill, self-efficacy, and well-being for themselves (Gitlin & Corcoran, 2005; Gitlin, Corcoran, Winter, Boyce, & Hauck, 2001; Gitlin et al., 2003).

Outcomes for people may include subjective impressions related to goals such as an improved outlook, confidence, hope, playfulness, self-efficacy, sustainability of valued occupations, resilience, or perceived well-being. Outcomes also may include measurable increments of progress in factors related to occupational performance such as skin integrity, amount of sleep, endurance, desire, initiation, balance, visual-motor skills, and at the participation level, activity participation and community re-integration. Outcomes for organizations may include increased workplace morale, productivity, reduced injuries, and improved worker satisfaction. Outcomes for populations may include health promotion, social justice, and access to services. The definitions and connotations of outcomes are specific to clients, groups, and organizations as well as to payers and regulators. Specific outcomes as well as documentation of those outcomes vary by practice setting and are influenced by the particular stakeholders in each setting.

The focus on outcomes is interwoven throughout the process of occupational therapy. The occupational therapist and client collaborate during the

evaluation to identify the client's initial desired outcomes related to engagement in valued occupations or daily life activities. During intervention implementation and re-evaluation, the client and therapist and, when appropriate, the occupational therapy assistant, may modify desired outcomes to accommodate changing needs, contexts, and performance abilities. As further analysis of occupational performance and the development of the intervention plan occur, the occupational therapist and client may redefine the desired outcomes.

Implementation of the outcomes process includes the following steps:

1. Selecting types of outcomes and measures, including but not limited to **occupational performance, adaptation, health and wellness, participation, prevention, self-advocacy, quality of life, and occupational justice** (see Table 10).
 - Selecting outcome measures early in the intervention process (see "Evaluation" above)
 - Selecting outcome measures that are valid, reliable, and appropriately sensitive to change in the client's occupational performance and are consistent with the outcomes
 - Selecting outcome measures or instruments for a particular client that are congruent with client goals
 - Selecting outcome measures that are based on their actual or purported ability to predict future outcomes.
2. Using outcomes to measure progress and adjust goals and interventions
 - Comparing progress toward goal achievement to outcomes throughout the intervention process
 - Assessing outcome use and results to make decisions about the future direction of intervention (e.g., continue intervention, modify intervention, discontinue intervention, provide follow-up, refer to other services).

TABLE 10. TYPES OF OUTCOMES

The examples listed specify how the broad outcome of engagement in occupation may be operationalized. The examples are not intended to be all-inclusive.

Outcome	Description
Occupational performance	<p>The act of doing and accomplishing a selected activity or occupation that results from the dynamic transaction among the client, the context, and the activity. Improving or enabling skills and patterns in occupational performance leads to engagement in occupations or activities (adapted in part from Law et al., 1996, p. 16).</p> <ul style="list-style-type: none"> • <i>Improvement</i>—Used when a performance limitation is present. These outcomes document increased occupational performance for the person, organization, or population. Outcome examples may include (1) the ability of a child with autism to play interactively with a peer (person); (2) the ability of an older adult to return to the home from a skilled-nursing facility (person); (3) decreased incidence of back strain in nursing personnel as a result of an in-service education program in body mechanics for carrying out job duties that require bending, lifting, and so forth (organizations); and (d) construction of accessible playground facilities for all children in local city parks (populations). • <i>Enhancement</i>—Used when a performance limitation is not currently present. These outcomes document the development of performance skills and performance patterns that augment existing performance or prevent potential problems from developing in life occupations. Outcome examples may include (1) increased confidence and competence of teenage mothers to parent their children as a result of structured social groups and child development classes (person); (2) increased membership of the local senior citizen center as a result of diverse social wellness and exercise programs (organization); (3) increased ability by school staff to address and manage school-age youth violence as a result of conflict resolution training to address “bullying” (organizations); and (4) increased opportunities for seniors to participate in community activities due to ride share programs (populations).
Adaptation	<p>A change in response approach that the client makes when encountering an occupational challenge. “This change is implemented when the [client’s] customary response approaches are found inadequate for producing some degree of mastery over the challenge” (adapted from Schultz & Schkade, 1997, p. 474). Examples of adaptation outcomes include (1) clients modifying their behaviors to earn privileges at an adolescent treatment facility (person); (2) a company redesigning the daily schedule to allow for an even workflow and to decrease times of high stress (organizations); and (3) a community making available accessible public transportation and erecting public and “reserved” benches for older adults to socialize and rest (populations).</p>
Health and wellness	<p>Health is a resource for everyday life, not the objective of living. For individuals, it is a state of physical, mental, and social well-being, as well as a positive concept emphasizing social and personal resources and physical capacities (WHO, 1986). Health of organizations and populations includes these individual aspects but also includes social responsibility of members to society as a whole. <i>Wellness</i> is “[a]n active process through which individuals [organizations or populations] become aware of and make choices toward a more successful existence” (Hettler, 1984, p. 1170). Wellness is more than a lack of disease symptoms; it is a state of mental and physical balance and fitness (adapted from <i>Taber’s Cyclopedic Medical Dictionary</i>, 1997, p. 2110). Outcome examples may include (1) participation in community outings by a client with schizophrenia in a group home (person); (2) implementation of a company-wide program to identify problems and solutions for balance among work, leisure, and family life (organizations); and (3) decreased incidence of childhood obesity (populations).</p>
Participation	<p>Engagement in desired occupations in ways that are personally satisfying and congruent with expectations within the culture.</p>

TABLE 10. TYPES OF OUTCOMES*(Continued)*

Outcome	Description
Prevention	<p>“[H]ealth promotion is equally and essentially concerned with creating the conditions necessary for health at individual, structural, social, and environmental levels through an understanding of the determinants of health: peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice, and equity” (Kronenberg, Algado, & Pollard, 2005, p. 441). Occupational therapy promotes a healthy lifestyle at the individual, group, organizational, community (societal), and governmental or policy level (adapted from Brownson & Scaffa, 2001). Outcome examples may include (1) appropriate seating and play area for a child with orthopedic impairments (person); (2) implementation of a program of leisure and educational activities for a drop-in center for adults with severe mental illness (organizations); and (3) access to occupational therapy services in underserved areas regardless cultural or ethnic backgrounds (populations).</p>
Quality of life	<p>The dynamic appraisal of the client's life satisfaction (perceptions of progress toward one's goals), hope (the real or perceived belief that one can move toward a goal through selected pathways), self-concept (the composite of beliefs and feelings about oneself), health and functioning (including health status, self-care capabilities, and socioeconomic factors, e.g., vocation, education, income; adapted from Radomski, 1995; Zhan, 1992). Outcomes may include (1) full and active participation of a deaf child from a hearing family during a recreational activity (person); (2) residents being able to prepare for outings and travel independently as a result of independent-living skills training for care providers of a group (organization); and (3) formation of a lobby to support opportunities for social networking, advocacy activities, and sharing scientific information for stroke survivors and their families (population).</p>
Role competence	<p>The ability to effectively meet the demands of roles in which the client engages.</p>
Self-advocacy	<p>Actively promoting or supporting oneself or others (individuals, organizations, or populations); requires an understanding of strengths and needs, identification of goals, knowledge of legal rights and responsibilities, and communicating these aspects to others (adapted from Dawson, 2007). Outcomes may include (1) a student with a learning disability requesting and receiving reasonable accommodations such as textbooks on tape (person); (2) a grassroots employee committee requesting and procuring ergonomically designed keyboards for their computers at work (organization); and (3) people with disabilities advocating for universal design with all public and private construction (population).</p>
Occupational justice	<p>Access to and participation in the full range of meaningful and enriching occupations afforded to others. Includes opportunities for social inclusion and the resources to participate in occupations to satisfy personal, health, and societal needs (adapted from Townsend & Wilcock, 2004). Outcomes may include (1) people with intellectual disabilities serving on an advisory board to establish programs offered by a community recreation center (person); (2) workers who have enough of break time to have lunch with their young children at day care centers (organization); (3) people with persistent mental illness welcomed by community recreation center due to anti-stigma campaign (organization); and (4) alternative adapted housing options for older adult to “age in place” (populations).</p>

Historical and Future Perspectives on the *Occupational Therapy Practice Framework*

The *Occupational Therapy Practice Framework* emerged out of the examination of documents related to *Uniform Terminology*. The first document was the *Occupational Therapy Product Output Reporting System and Uniform Terminology for Reporting Occupational Therapy Services* (AOTA, 1979). This original text created consistent terminology that could be used in official documents, practice, and education. The second edition of *Uniform Terminology for Occupational Therapy* (AOTA, 1989) was adopted by the AOTA Representative Assembly (RA) and published in 1989. The document focused on delineating and defining only the occupational performance areas and occupational performance components that are addressed in occupational therapy direct services. The last revision, *Uniform Terminology for Occupational Therapy—Third Edition* (UT-III; AOTA, 1994), was adopted by the RA in 1994 and was “expanded to reflect current practice and to incorporate contextual aspects of performance” (p. 1047). Each revision reflected changes in current practice and provided consistent terminology that could be used by the profession. Originally a document that responded to a federal requirement to develop a uniform reporting system, the text gradually shifted to describing and outlining the domain of concern of occupational therapy.

In the fall of 1998, the AOTA Commission on Practice (COP) embarked on the journey that culminated in the *Occupational Therapy Practice Framework: Domain and Process* (*Framework*; AOTA, 2002b). During that time, AOTA published *The Guide to Occupational Therapy Practice* (Moyers, 1999), which outlined many of the contemporary shifts of the day, and the COP careful-

ly reviewed this document. In light of those changes and the feedback received during the review process of *UT-III*, the COP decided that practice needs had changed and that it was time to develop a different kind of document.

Because the *Framework* is an official AOTA document, it is reviewed on a 5-year cycle. During the review period, the COP collected feedback from membership, scholars, authors, and practitioners to determine the needed changes. Revisions ensued to maintain the integrity of the *Framework* and change only what was necessary. The revisions reflect the contributions of the current COP, refinement of the writing of the document, and emerging concepts and changes in occupational therapy. The rationale for specific changes is listed in Table 11.

The *Framework* is an evolving document and will undergo another review in 5 years, which again will examine the usefulness of the document and need for further refinements and change. The next iteration likely will change as the result of the profession’s progress toward AOTA’s 2017 *Centennial Vision* of “occupational therapy [as] a powerful, widely recognized, science-driven, and evidence-based profession with a globally connected and diverse workforce meeting society’s occupational needs” (AOTA, 2007a).

Although the *Framework* represents the latest in the profession’s evolution, it builds on a set of values that the profession of occupational therapy has held since its founding in 1917. This founding vision had at its center a profound belief in the value of therapeutic occupations as a way to remediate illness and maintain health (Slagle, 1924). It emphasized the importance of establishing a therapeutic relationship with each client and designing a treatment plan based on knowledge about the individual’s environment, values, goals, and desires (Meyer, 1922). And it advocated for a scientific practice based on systematic observation

TABLE 11. SUMMARY OF SIGNIFICANT *FRAMEWORK* REVISIONS

Domain Area	Change	Intended Benefit	Rationale
Title	Supporting Health and Participation in Life Through Engagement in Occupation	Increase clarity of intent	Changing from the original title of Figure 1, Engagement in Occupation to Support Participation in Context or Contexts, emphasizes that the vehicle for occupational therapy to health and participation is engagement in occupation. Deleted “in context” to shorten the title, because it is discussed in the text and implied by the definition of occupation.
Spirituality	Move from Context to Client Factor	Reflect the way in which occupational therapy practitioners view and analyze meaning, values, and beliefs of a broad range of clients	More commonly, individuals consider spirituality residing within the client rather than as part of a context. Moreira-Almeida and Koenig (2006) discussed spirituality, religion, and personal beliefs as components of quality of life. Their definitions are included in the text.
Performance Skills	Broaden categories with more generic language	Provide language inclusive of a broad range of assessments and interventions as well as commonly used terms in the literature related to skills	<p>Based on her work with the Assessment of Motor and Process Skills (AMPS), Fisher (2006) provides the most distinct categories and definitions of skill functions. An attempt is made in this revision to address critiques of the 2002 <i>Framework</i> that Fisher’s categories are limited. To broaden skill categories to more generic and inclusive language, the COP considered at length the differences among <i>body functions, abilities, capacities, skills, levels of skills, and components of occupations</i>. In most articles, authors use terms related to skills interchangeably with <i>abilities</i> and <i>capacities</i>, confusing the issue.</p> <p>To add to the difficulty in providing readers with a list of performance skills, the proposed categories are not completely distinct from one another. Without creating an artificial distinction between categories, it is necessary to tolerate the overlap in these skill areas. For example, according to Filley (2001), “skill learning and acquisition of praxis may well be identical phenomena” (p. 89). Perception often is discussed in cognitive literature; social cognition implies a specific skill set, as do social-emotional skills; and sensory-motor skills are often considered together.</p>
Rest and Sleep	Move from ADL to Area of Occupation	Highlight the importance of rest and sleep, especially as they relate to supporting or hindering engagement in other areas of occupation	Rest and sleep are two of the four main categories of occupation discussed by Adolf Meyer (1922). Unlike any other area of occupation, all people rest as a result of engaging in occupations and engage in sleep for multiple hours per day throughout their life span. Within the occupation of rest and sleep are activities such as preparing the self and environment for sleep, interactions with others who share the sleeping space, reading or listening to music to fall asleep, napping, dreaming, nighttime care of toileting needs, nighttime caregiving duties, and ensuring safety. Sleep significantly affects all other areas of occupation. Jonsson (2007) suggested that providing sleep prominence in the framework as an area of occupation will promote the consideration of lifestyle choices as an important aspect of participation and health.
Context	Change to context and environment	Allow use of broader language consistent with external audiences and existing occupational therapy theories	The terms <i>context</i> and <i>environment</i> are not the same but often are used interchangeably. In the general literature, environment is used more frequently. Occupational therapy theories often use environment rather than context. This change allows for a cross-walk between the two terms. In the narrative, context is used to include environment.

(Continued)

TABLE 11. SUMMARY OF SIGNIFICANT *FRAMEWORK* REVISIONS*(Continued)*

Domain Area	Change	Intended Benefit	Rationale
Occupational justice	Include narrative about the importance of social justice specific to occupational therapy	Highlight the importance of occupational therapy values in the global community	The discussion of concepts of occupational justice encourages practitioners to examine the multiple contributors to engagement and social participation. Townsend and Wilcock (2004) are leaders in our understanding of this important concept. Gupta and Walloch (2006) provide a nice summary of this work.
Process Area	Change	Intended Benefit	Rationale
Client	Include person, organization, population	Broaden the scope of occupational therapy services and provides language consistent with advocacy and policy-making groups.	Consistent with <i>The Guide to Occupational Therapy Practice</i> (Moyers & Dale, 2007). Language in occupational therapy literature often is focused on the individual or person. This change highlights the way in which occupational therapy contributes to groups of persons, populations, and organizations, often in nontraditional practice arenas.
Clinical Reasoning	Identify the way in which the practitioner's view of the client is informed via knowledge, skills, and evidence	Highlight the importance of the practitioner's problem-solving skills in the interaction with the client	Clinical reasoning was expanded in the document to emphasize its importance throughout the occupational therapy process. Intrinsic to any interaction between the practitioner and the client is the critical thinking implicit within clinical-reasoning skills that inform and guide the intervention.
Activity Analysis Activity Synthesis	Include discussion about analyzing activities in and of themselves and in relation to the client	Highlight the importance of this critical skill that informs intervention	Occupational therapy practitioners have a high level of skill in identifying the demands of an activity and then synthesizing this information by comparing it with the client's needs and abilities to identify specific occupational performance difficulties.
Self-Advocacy	Include self-advocacy as an outcome	Provide focus on empowerment as a key feature in health and participation	When working with individuals, populations, or organizations, occupational therapy provides intervention, which promotes self-advocacy as a means toward improved health and participation.
Evidence-based practice	Emphasize the role of research in informing practice	Articulate the value of a science-driven profession	Occupational therapy is a profession founded on basic and applied science informing practice.

TABLE 11. SUMMARY OF SIGNIFICANT *FRAMEWORK* REVISIONS*(Continued)*

Terminology	Change	Intended Benefit	Rationale
Transactive and interactive	Include the idea that areas of the domain are transactive and the client is interactive	Create distinction between the relationships of concepts within the domain and interactions between clients and practitioners	<i>Transactive</i> is used to describe the dynamic way in which the areas of the occupational therapy domain intersect. <i>Interactive</i> is the way in which clients and occupational therapy practitioners engage together or with others. Occupational therapy is therefore the interaction between practitioners and clients within one or more areas of the domain to meet the overarching objective of engagement in occupation to support health and participation.
Activity/occupation and purposeful activity	Use occupation to include activity in the narrative	To increase readability of the document	Recognizing the work of scholars in the field, the authors acknowledge the differences in activity and occupation. However, this document does not engage in this debate. In the <i>Framework</i> , occupation is used to include activity. Activity is used specific to tasks considered in isolation of the client. Purposeful activity is used to describe a type of intervention determined by the therapist to be “purposeful” for achieving the goals of intervention, not in judging whether or not a client’s chosen activity is purposeful or not.
Outcomes	Change	Intended Benefit	Rationale
Outcomes	Added occupational justice and self-advocacy to Table 10: Types of Outcomes	To acknowledge occupational therapy’s commitment to occupational justice and self-determination for all people	Recognizing that an important outcome of occupational therapy intervention may be enabling all individuals to be able to meet basic needs and to have equal opportunities and life chances to reach toward his or her potential through engagement in diverse and meaningful occupation.

and treatment (Dunton, 1934). Paraphrased using today’s lexicon, the founders proposed a vision that was occupation-based, client-centered, contextual, and evidence-based—the vision articulated in the *Framework* today.

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Glossary

A

Activities of daily living (ADLs)

Activities oriented toward taking care of one's own body (adapted from Rogers & Holm, 1994, pp. 181–202). **ADL** also is referred to as *basic activities of daily living (BADL)* and *personal activities of daily living (PADL)*. These activities are “fundamental to living in a social world; they enable basic survival and well-being” (Christiansen & Hammecker, 2001, p. 156) (see Table 1 for definitions of terms).

Activity (Activities)

A class of human actions that are goal directed.

Activity analysis

“...addresses the typical demands of an activity, the range of skills involved in its performance, and the various cultural meanings that might be ascribed to it” (Crepeau, 2003, p. 192).

Activity demands

The aspects of an activity, which include the objects and their physical properties, space, social demands, sequencing or timing, required actions or skills, and required underlying body functions and body structures needed to carry out the activity (see Table 3).

Adaptation

The response approach the client makes encountering an occupational challenge. “This change is implemented when the individual's customary response approaches are found inadequate for producing some degree of mastery over the challenge” (Schultz & Schkade, 1997, p. 474).

Advocacy

The “pursuit of influencing outcomes—including public policy and resource allocation decisions within political, economic, and social systems and institutions—that directly affect people's lives” (Advocacy Institute, 2001, as cited in Goodman-Lavey & Dunbar, 2003, p. 422).

Analysis of occupational performance

Part of the evaluation process. Collecting information via assessment tools designed to observe, measure, and inquire about selected factors that support or hinder occupational performance.

Areas of occupations

Various kinds of life activities in which people engage, including the following categories: ADLs, IADLs, rest and sleep, education, work, play, leisure, and social participation (see Table 1).

Assessment

“Specific tools or instruments that are used during the evaluation process” (AOTA, 2005, p. 663).

B

Belief

Any cognitive content held as true by the client (Moyers & Dale, 2007).

Body functions

“The physiological functions of body systems (including psychological functions)” (WHO, 2001, p. 10) (see Table 2).

Body structures

“Anatomical parts of the body such as organs, limbs, and their components [that support body function]” (WHO, 2001, p. 10) (see Table 2).

C

Client

The entity that receives occupational therapy services. Clients may include (1) individuals and other persons relevant to the individual's life, including family, caregivers, teachers, employers, and others who also may help or be served indirectly; (2) organizations such as business, industries, or agencies; and (3) populations within a community (Moyers & Dale, 2007).

Client-centered approach

An orientation that honors the desires and priorities of clients in designing and implementing interventions (adapted from Dunn, 2000a, p. 4).

Client factors

Those factors residing within the client that may affect performance in areas of occupation. Client factors include values, beliefs, and spirituality; body functions; and body structures (see Table 2).

Clinical reasoning

“Complex multi-faceted cognitive process used by practitioners to plan, direct, perform, and reflect on intervention” (Crepeau et al., 2003, p. 1027).

Communication and social skills

Actions or behaviors a person uses to communicate and interact with others in an interactive environment (Fisher, 2006).

Cognitive skills

Actions or behaviors a client uses to plan and manage the performance of an activity.

Context

Refers to a variety of interrelated conditions within and surrounding the client that influence performance. Contexts include cultural, personal, temporal, and virtual (see Table 6).

Co-occupations

Activities that implicitly involve at least two people (Zemke & Clark, 1996).

Cultural (context)

“Customs, beliefs, activity patterns, behavior standards, and expectations accepted by the society of which the [client] is a member. Includes ethnicity and values as well as political aspects, such as laws that affect access to resources and affirm personal rights. Also includes opportunities for education, employment, and economic support” (AOTA, 1994, p. 1054).

D

Domain

A sphere of activity, concern, or function (*American Heritage Dictionary*, 2006).

E

Education

Includes learning activities needed when participating in an environment (see Table 1).

Emotional regulation skills

Actions or behaviors a client uses to identify, manage, and express feelings while engaging in activities or interacting with others.

Engagement

The act of sharing activities.

Environment

The external physical and social environment that surrounds the client and in which the client's daily life occupations occur (see Table 6).

Evaluation

“The process of obtaining and interpreting data necessary for intervention. This includes planning for and documenting the evaluation process and results” (AOTA, 2005, p. 663).

G

Goals

“The result or achievement toward which effort is directed; aim; end” (*Webster's Encyclopedic Unabridged Dictionary of the English Language*, 1994, p. 605).

H

Habits

“Automatic behavior that is integrated into more complex patterns that enable people to function on a day-to-day basis...” (Neistadt & Crepeau, 1998, p. 869). Habits can be useful, dominating,

or impoverished and either support or interfere with performance in areas of occupation.

Health

Health is a resource for everyday life, not the objective of living. It is a state of complete physical, mental, and social well-being, as well as a positive concept emphasizing social and personal resources, as well as physical capacities (adapted from WHO, 1986).

Health promotion

“[T]he process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental, and social well-being, an individual or group must be able to identify and realize aspirations, to satisfy needs, and to change or cope with the environment” (WHO, 1986).

“[C]reating the conditions necessary for health at individual, structural, social, and environmental levels through an understanding of the determinants of health: peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice, and equity” (Trentham & Cockburn, 2005, p. 441).

Hope

The real or perceived belief that one can move toward a goal through selected pathways (Lopez et al., 2004).

/

Identity

“A composite definition of the self and includes an interpersonal aspect...an aspect of possibility or potential (who we might become), and a values aspect (that suggests importance and provides a stable basis for choices and decisions)... Identity can be viewed as the superordinate view of ourselves that includes both self-esteem and self-concept but also importantly reflects and is influenced by the larger social world in which we find ourselves” (Christiansen, 1999, pp. 548–549).

Independence

“A self-directed state of being characterized by an individual’s ability to participate in necessary and preferred occupations in a satisfying manner irrespective of the amount or kind of external assistance desired or required

- Self-determination is essential to achieving and maintaining independence;
- An individual’s independence is unrelated to whether he or she performs the activities related to an occupation himself or herself, performs the activities in an adapted or modified environment, makes use of various devices or alternative strategies, or oversees activity completion by others;
- Independence is defined by the individual’s culture and values, support systems, and ability to direct his or her life; and
- An individual’s independence should not be based on preestablished criteria, perception of outside observers, or how independence is accomplished” (AOTA, 2002a, p. 660).

Instrumental activities of daily living (IADLs)

Activities to support daily life within the home and community that often require more complex interactions than self-care used in ADL (see Table 1).

Interdependence

The “reliance that people have on each other as a natural consequence of group living” (Christiansen & Townsend, 2004, p. 277). “Interdependence engenders a spirit of social inclusion, mutual aid, and a moral commitment and responsibility to recognize and support difference” (p. 146).

Interests

“What one finds enjoyable or satisfying to do” (Kielhofner, 2002, p. 25).

Intervention

The process and skilled actions taken by occupational therapy practitioners in collaboration with

the client to facilitate engagement in occupation related to health and participation. The intervention process includes the plan, implementation, and review (see Table 7).

Intervention approaches

Specific strategies selected to direct the process of interventions that are based on the client's desired outcome, evaluation date, and evidence (see Table 9).

L

Leisure

"A nonobligatory activity that is intrinsically motivated and engaged in during discretionary time, that is, time not committed to obligatory occupations such as work, self-care, or sleep" (Parham & Fazio, 1997, p. 250).

M

Motor and praxis skills

Motor

Actions or behaviors a client uses to move and physically interact with tasks, objects, contexts, and environments (adapted from Fisher, 2006). Includes planning, sequencing, and executing novel movements.

Also see Praxis.

O

Occupation

"Goal-directed pursuits that typically extend over time have meaning to the performance, and involve multiple tasks" (Christiansen et al., 2005, p. 548).

"Daily activities that reflect cultural values, provide structure to living, and meaning to individuals; these activities meet human needs for self-care, enjoyment, and participation in society" (Crepeau et al., 2003, p. 1031).

"Activities that people engage in throughout their daily lives to fulfill their time and give life

meaning. Occupations involve mental abilities and skills and may or may not have an observable physical dimension" (Hinojosa & Kramer, 1997, p. 865).

"[A]ctivities...of everyday life, named, organized, and given value and meaning by individuals and a culture. Occupation is everything people do to occupy themselves, including looking after themselves...enjoying life...and contributing to the social and economic fabric of their communities" (Law et al., 1997, p. 32).

"A dynamic relationship among an occupational form, a person with a unique developmental structure, subjective meanings and purpose, and the resulting occupational performance" (Nelson & Jepson-Thomas, 2003, p. 90).

"[C]hunks of daily activity that can be named in the lexicon of the culture" (Zemke & Clark, 1996, p. vii).

Occupation-based intervention

A type of occupational therapy intervention—a client-centered intervention in which the occupational therapy practitioner and client collaboratively select and design activities that have specific relevance or meaning to the client and support the client's interests, need, health, and participation in daily life.

Occupational justice

"Justice related to opportunities and resources required for occupational participation sufficient to satisfy personal needs and full citizenship" (Christiansen & Townsend, 2004, p. 278). To experience meaning and enrichment in one's occupations; to participate in a range of occupations for health and social inclusion; to make choices and share decision-making power in daily life; and to receive equal privileges for diverse participation in occupations (Townsend & Wilcock, 2004).

Occupational performance

The act of doing and accomplishing a selected activity or occupation that results from the

dynamic transaction among the client, the context, and the activity. Improving or enabling skills and patterns in occupational performance leads to engagement in occupations or activities (adapted in part from Law et al., 1996, p. 16).

Occupational profile

A summary of the client's occupational history, patterns of daily living, interests, values, and needs.

Occupational science

An interdisciplinary academic discipline in the social and behavioral sciences dedicated to the study of the form, the function, and the meaning of human occupations (Zemke & Clark, 1996).

Occupational therapy

The practice of occupational therapy means the therapeutic use of everyday life activities (occupations) with individuals or groups for the purpose of participation in roles and situations in home, school, workplace, community, and other settings. Occupational therapy services are provided for the purpose of promoting health and wellness and to those who have or are at risk for developing an illness, injury, disease, disorder, condition, impairment, disability, activity limitation, or participation restriction. Occupational therapy addresses the physical, cognitive, psychosocial, sensory, and other aspects of performance in a variety of contexts to support engagement in everyday life activities that affect health, well-being, and quality of life (AOTA, 2004a).

Organizations

Entities with a common purpose or enterprise such as businesses, industries, or agencies.

Outcomes

What occupational therapy actually achieves for the consumers of its services (adapted from Fuhrer, 1987). Change desired by the client that can focus on any area of the client's occupational performance (adapted from Kramer, McGonigel, & Kaufman, 1991).

P

Participation

"Involvement in a life situation" (WHO, 2001, p. 10).

Performance patterns

Patterns of behavior related to daily life activities that are habitual or routine. They can include habits, routines, rituals, and roles (see Table 5).

Performance skills

The abilities clients demonstrate in the actions they perform (see Table 4).

Persons

Individuals, including families, caregivers, teachers, employees, and relevant others.

Personal

"Features of the individual that are not part of a health condition or health status" (WHO, 2001, p. 17). Personal context includes age, gender, socioeconomic, and educational status. Can also include organizational levels (i.e., volunteers, employees) and population levels (i.e., members of a society).

Physical environment

The natural and built nonhuman environment and objects in them.

Play

"Any spontaneous or organized activity that provides enjoyment, entertainment, amusement, or diversion" (Parham & Fazio, 1997, p. 252) (see Table 1).

Populations

Large groups as a whole, such as refugees, homeless veterans, and people who need wheelchairs.

Praxis

Skilled purposeful movements (Heilman & Rothi, 1993). The ability to carry out sequential motor acts as part of an overall plan rather than individual acts (Liepmann, 1920). The ability to carry out learned

motor activity, including following through on a verbal command, visual spatial construction, ocular and oral-motor skills, imitation of a person or an object, and sequencing actions (Ayres, 1985; Filley, 2001). Organization of temporal sequences of actions within the spatial context; which form meaningful occupations (Blanche & Parham, 2002).

Also see Motor.

Preparatory methods

Methods and techniques that prepare the client for occupational performance. Used in preparation for or concurrently with purposeful and occupation-based activities.

Prevention

“[H]ealth promotion is equally and essentially concerned with creating the conditions necessary for health at individual, structural, social, and environmental levels through an understanding of the determinants of health: peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice, and equity” (Kronenberg, Algado, & Pollard, 2005, p. 441).

Promoting a healthy lifestyle at the individual, group, organizational, community (societal), governmental/policy level (adapted from Brownson & Scaffa, 2001).

Process

A description of the way in which occupational therapy practitioners operationalize their expertise to provide services to clients. The process includes evaluation, intervention, and outcome monitoring; occurs within the purview of the domain; and involves collaboration among the occupational therapist, occupational therapy assistant, and the client.

Purposeful activity

A goal-directed behavior or activity within a therapeutically designed context that leads to an occu-

pation or occupations. Specifically selected activities that allow the client to develop skills that enhance occupational engagement.

Q

Quality of life

A client's dynamic appraisal of life satisfactions (perceptions of progress toward identified goals), self-concept (the composite of beliefs and feelings about themselves), health and functioning (including health status, self-care capabilities), and socioeconomic factors (e.g., vocation, education, income) (adapted from Radomski, 1995; Zhan, 1992).

R

Re-evaluation

A reassessment of the client's performance and goals to determine the type and amount of change.

Rest

Quiet and effortless actions that interrupt physical and mental activity, resulting in a relaxed state (Nurit & Michel, 2003, p. 227).

Ritual

Symbolic actions with spiritual, cultural, or social meaning, contributing to the client's identity and reinforcing the client's values and beliefs (Fiese et al., 2002; Segal, 2004). Rituals are highly symbolic, with a strong affective component and representative of a collection of events.

Roles

Roles are sets of behaviors expected by society, shaped by culture, and may be further conceptualized and defined by the client.

Routines

Patterns of behavior that are observable, regular, repetitive, and that provide structure for daily life. They can be satisfying, promoting, or damaging. Routines require momentary time commitment

and are embedded in cultural and ecological contexts (Fiese et al., 2002; Segal, 2004).

Self-advocacy

Understanding your strengths and needs, identifying your personal goals, knowing your legal rights and responsibilities, and communicating these to others (Dawson, 2007).

Sensory–perceptual skills

Actions or behaviors a client uses to locate, identify, and respond to sensations and to select, interpret, associate, organize, and remember sensory events via sensations that include visual, auditory, proprioceptive, tactile, olfactory, gustatory, and vestibular sensations.

Sleep

“A natural periodic state of rest for the mind and body, in which the eyes usually close and consciousness is completely or partially lost, so that there is a decrease in bodily movement and responsiveness to external stimuli. During sleep the brain in humans and other mammals undergoes a characteristic cycle of brain-wave activity that includes intervals of dreaming” (*The Free Dictionary*, 2007) (see Table 1).

A series of activities resulting in going to sleep, staying asleep, and ensuring health and safety through participation in sleep involving engagement with the physical and social environments.

Social environment

Is constructed by the presence, relationships, and expectations of persons, organizations, and populations.

Social justice

“Ethical distribution and sharing of resources, rights, and responsibilities between people, recognizing their equal worth as citizens. [It recognizes] ‘their equal right to be able to meet basic needs, the need to spread opportunities and life chances

as widely as possible, and finally the requirement that we reduce and where possible eliminate unjustified inequalities” (Commission on Social Justice, 1994, p. 1).

“The promotion of social and economic change to increase individual, community, and political awareness, resources, and opportunity for health and well-being” (Wilcock, 2006, p. 344).

Social participation

“Organized patterns of behavior that are characteristic and expected of an individual in a given position within a social system” (Mosey, 1996, p. 340) (see Table 1).

Spirituality

“[T]he personal quest for understanding answers to ultimate questions about life, about meaning, and about relationship with the sacred or transcendent, which may (or may not) lead to or arise from the development of religious rituals and the formation of community” (Moreira-Almeida & Koenig, 2006, p. 844).

T

Temporal

“Location of occupational performance in time” (Neistadt & Crepeau, 1998, p. 292). The experience of time as shaped by engagement in occupations. The temporal aspects of occupations “which contribute to the patterns of daily occupations” are “the rhythm...tempo...synchronization...duration...and sequence” (Larson & Zemke, 2004, p. 82; Zemke, 2004, p. 610). It includes stages of life, time of day, duration, rhythm of activity, or history.

Transactional

A process that involves two or more individuals or elements that reciprocally and continually influence and affect one another through the ongoing relationship (Dickie, Cutchin, & Humphry, 2006).

V

Values

Principles, standards, or qualities considered worthwhile or desirable by the client who holds them (Moyers & Dale, 2007).

Virtual

Environment in which communication occurs by means of airways or computers and an absence of physical contact. Includes simulated or real-time or near-time existence of an environment, such as chat rooms, email, video conferencing, and radio transmissions.

W

Wellness

“An active process through which individuals become aware of and make choices toward a more successful existence” (Hettler, 1984, p. 1117). Wellness is more than a lack of disease symptoms. It is a state of mental and physical balance and fitness (adapted from *Taber's Cyclopedia Medical Dictionary*, 1997, p. 2110).

Work

“Activities needed for engaging in remunerative employment or volunteer activities” (Mosey, 1996, p. 341) (see Table 1).

References

- American Heritage Dictionary of the English Language* (4th ed.). (2006). Boston: Houghton-Mifflin.
- American Occupational Therapy Association. (1979). *Occupational therapy product output reporting system and uniform terminology for reporting occupational therapy services*. (Available from American Occupational Therapy Association, 4720 Montgomery Lane, PO Box 31220, Bethesda, MD 20824-1220)
- American Occupational Therapy Association. (1989). *Uniform terminology for occupational therapy* (2nd ed.). (Available from American Occupational Therapy Association, 4720 Montgomery Lane, PO Box 31220, Bethesda, MD 20824-1220)
- American Occupational Therapy Association. (1994). Uniform terminology for occupational therapy (3rd ed.). *American Journal of Occupational Therapy*, 48, 1047–1054.
- American Occupational Therapy Association. (2002a). Broadening the construct of independence [Position Paper]. *American Journal of Occupational Therapy*, 56, 660.
- American Occupational Therapy Association. (2002b). Occupational therapy practice framework: Domain and process. *American Journal of Occupational Therapy*, 56, 609–639.
- American Occupational Therapy Association. (2004a). *Definition of occupational therapy practice for the AOTA Model Practice Act*. Bethesda, MD: Author. (Available from the State Affairs Group, 4720 Montgomery Lane, PO Box 31220, Bethesda, MD 20824-1220)
- American Occupational Therapy Association. (2004b). Guidelines for supervision, roles, and responsibilities during the delivery of occupational therapy services. *American Journal of Occupational Therapy*, 58, 663–667.
- American Occupational Therapy Association. (2004c). Occupational therapy's commitment to nondiscrimination and inclusion (edited 2004). *American Journal of Occupational Therapy*, 58, 666.
- American Occupational Therapy Association. (2005). Standards of practice for occupational therapy. *American Journal of Occupational Therapy*, 59, 663–665.
- American Occupational Therapy Association. (2006). Policy 1.44: Categories of occupational therapy personnel. In *Policy manual* (2007 ed., pp. 33–34). Bethesda, MD: Author.
- American Occupational Therapy Association. (2007a). AOTA Centennial Vision and executive summary. *American Journal of Occupational Therapy*, 61, 613–614.
- American Occupational Therapy Association. (2007b). Specialized knowledge and skills in feeding, eating, and swallowing for occupational therapy practice. *American Journal of Occupational Therapy*, 61, 686–700.
- Ayres, A. J. (1972). *Sensory integration and learning disorders*. Los Angeles: Western Psychological Services.

- Ayres, A. J. (1985). *Developmental dyspraxia and adult onset apraxia*. Torrance, CA: Sensory Integration International.
- Ayres, A. J. (2005). *Sensory integration and the child*. Los Angeles: Western Psychological Services.
- Baum, C. M., Bass-Haugen, J., & Christiansen, C. H. (2005). Person–environment–occupation–performance: A model for planning interventions for individuals and organizations. In C. H. Christiansen, C. M. Baum, & J. Bass-Haugen (Eds.), *Occupational therapy: Performance, participation, and well-being* (3rd ed., pp. 373–392). Thorofare, NJ: Slack.
- Bergen, D. (Ed.). (1988). *Play as a medium for learning and development: A handbook of theory and practice*. Portsmouth, NH: Heinemann.
- Blanche, E. I., & Parham, L. D. (2002). Praxis and organization of behavior in time and space. In S. Smith Roley, E. I. Blanche, & R. C. Schaaf (Eds.), *Understanding the nature of sensory integration with diverse populations* (pp. 183–200). San Antonio, TX: Therapy Skill Builders.
- Bloom, B. S., Krathwohl, D. R., & Masia, B. B. (1984). *Taxonomy of educational objectives: The classification of educational goals*. New York: Longman.
- Brownson, C. A., & Scaffa, M. E. (2001). Occupational therapy in the promotion of health and the prevention of disease and disability. *American Journal of Occupational Therapy, 55*, 656–660.
- Calvert, G., Spence, C., & Stein, B. E. (Eds.). (2004). *The handbook of multisensory processes*. Cambridge, MA: MIT Press.
- Chapparo, C., & Ranka, J. (1997). The perceive, recall, plan, perform (PRPP) system of task analysis. In C. Chapparo & J. Ranka (Eds.), *Occupational performance model* (Australian Monograph 1, pp. 189–197). Sydney: Occupational Performance Network.
- Christiansen, C. H. (1999). Defining lives: Occupation as identity—An essay on competence, coherence, and the creation of meaning [1999 Eleanor Clarke Slagle Lecture]. *American Journal of Occupational Therapy, 53*, 547–558.
- Christiansen, C. H., & Baum, M. C. (Eds.). (1997). *Occupational therapy: Enabling function and well-being*. Thorofare, NJ: Slack.
- Christiansen, C., Baum, M. C., & Bass-Haugen, J. (Eds.). (2005). *Occupational therapy: Performance, participation, and well-being*. Thorofare, NJ: Slack.
- Christiansen, C. H., & Hammecker, C. L. (2001). Self care. In B. R. Bonder & M. B. Wagner (Eds.), *Functional performance in older adults* (pp. 155–175). Philadelphia: F. A. Davis.
- Christiansen, C. H., & Townsend, E. A. (Eds.). (2004). *Introduction to occupation: The art and science of living*. Upper Saddle River, NJ: Prentice Hall.
- Clark, F. A. (2000). The concept of habit and routine: A preliminary theoretical synthesis. *Occupational Therapy Journal of Research, 20*, 123S–137S.
- Cohn, E. S. (2001). Parent perspectives of occupational therapy using a sensory integration approach. *American Journal of Occupational Therapy, 55*, 285–294.
- Cohn, E. S., Miller, L. J., & Tickle-Degnan, L. (2000). Parental hopes for therapy outcomes: Children with sensory modulation disorders. *American Journal of Occupational Therapy, 54*, 36–43.
- Commission on Social Justice. (1994). *Social justice: Strategies for national renewal. The report of the Commission on Social Justice*. London: Vintage.
- Crepeau, E. (2003). Analyzing occupation and activity: A way of thinking about occupational performance. In E. Crepeau, E. Cohn, & B. Schell (Eds.), *Willard and Spackman's occupational therapy* (10th ed., pp. 189–198). Philadelphia: Lippincott Williams & Wilkins.
- Crepeau, E., Cohn, E., & Schell, B. (Eds.). (2003). *Willard and Spackman's occupational therapy*. Philadelphia: Lippincott Williams & Wilkins.
- Dawson, J. (2007). *Self-advocacy: A valuable skill for your teenager*. Retrieved January 20, 2007, from www.schwablearning.org
- Dickie, V., Cutchin, M. P., & Humphry, R. (2006). Occupation as transactional experience: A critique of individualism in occupational science. *Journal of Occupational Science, 13*, 83–93.
- Dunlea, A. (1996). An opportunity for co-adaptation: The experience of mothers and their infants who are blind. In R. Zemke & F. Clark (Eds.), *Occupational science: The evolving discipline* (pp. 227–342). Philadelphia: F. A. Davis.

- Dunn, W. (2000a). *Best practice in occupational therapy in community service with children and families*. Thorofare, NJ: Slack.
- Dunn, W. (2000b, Fall). Habit: What's the brain got to do with it? *Occupational Therapy Journal of Research*, 20(Suppl. 1), 6S–20S.
- Dunn, W., McClain, L. H., Brown, C., & Youngstrom, M. J. (1998). The ecology of human performance. In M. E. Neistadt & E. B. Crepeau (Eds.), *Willard and Spackman's occupational therapy* (9th ed., pp. 525–535). Philadelphia: Lippincott Williams & Wilkins.
- Dunton, W. R. (1934). The need for and value of research in occupational therapy. *Occupational Therapy and Rehabilitation*, 13, 325–328.
- Esdaile, S. A., & Olson J. A. (2004). *Mothering occupations: Challenge, agency, and participation*. Philadelphia: F. A. Davis.
- Fiese, B. H., Tomcho, T. J., Douglas, M., Josephs, K., Poltrock, S., & Baker, T. (2002). A review of 50 years of research on naturally occurring family routines and rituals: Cause for celebration? *Journal of Family Psychology*, 16, 381–390.
- Filley, C. M. (2001). *Neurobehavioral anatomy*. Boulder: University Press of Colorado.
- Fisher, A. (2006). Overview of performance skills and client factors. In H. Pendleton & W. Schultz-Krohn (Eds.), *Pedretti's occupational therapy: Practice skills for physical dysfunction* (pp. 372–402). St. Louis: Mosby/Elsevier.
- Foucault, M. (1973). *The birth of the clinic: An archaeology of medical perception*. New York: Pantheon Books.
- Fuhrer, M. J. (Ed.). (1987). *Rehabilitation outcomes analysis and measurement*. Baltimore: Brookes.
- Gitlin, L. N., & Corcoran, M. A. (2005). *Occupational therapy and dementia care: The Home Environmental Skill-Building Program for individuals and families*. Bethesda, MD: AOTA Press.
- Gitlin, L. N., Corcoran, M. A., Winter, L., Boyce, A., & Hauck, W. W. (2001). A randomized controlled trial of a home environmental intervention to enhance self-efficacy and reduce upset in family caregivers of persons with dementia. *The Gerontologist*, 41, 15–30.
- Gitlin, L. N., Winter, L., Corcoran, M., Dennis, M., Schinfeld, S., & Hauck, W. (2003). Effects of the Home Environmental Skill-Building Program on the caregiver–care recipient dyad: Six-month outcomes from the Philadelphia REACH initiative. *The Gerontologist*, 43, 532–546.
- Goodman-Lavey, M., & Dunbar, S. (2003). Federal legislative advocacy. In G. McCormack, E. Jaffe, & M. Goodman-Lavey (Eds.), *The occupational therapy manager* (4th ed., pp. 421–438). Bethesda, MD: AOTA Press.
- Gupta, J., & Walloch, C. (2006). Process of infusing social justice into the practice framework: A case study. *OT Practice*, 11(15), CE1–CE8.
- Gutman, S. A., Mortera, M. H., Hinojosa, J., & Kramer, P. (2007). Revision of the occupational therapy practice framework. *American Journal of Occupational Therapy*, 61, 119–126.
- Hakansson, C., Dahlin-Ivanoff, S., & Sonn, U. (2006). Achieving balance in everyday life. *Journal of Occupational Science*, 13, 74–82.
- Harrow, A. J. (1972). *A taxonomy of the psychomotor domain: A guide for developing behavioral objectives*. New York: McKay.
- Heilman, K. M., & Rothi, L. J. G. (1993). *Clinical neuropsychology* (3rd ed.). New York: Oxford University Press.
- Hettler, W. (1984). Wellness—The lifetime goal of a university experience. In J. D. Matarazzo, S. M. Weiss, J. A. Herd, N. E. Miller, & S. M. Weiss (Eds.), *Behavioral health: A handbook of health enhancement and disease prevention* (p. 1117). New York: Wiley.
- Hinojosa, J., & Kramer, P. (1997). Fundamental concepts of occupational therapy: Occupation, purposeful activity, and function [Statement]. *American Journal of Occupational Therapy*, 51, 864–866.
- Jackson, J. (1998a). Contemporary criticisms of role theory. *Journal of Occupational Science*, 5(2), 49–55.
- Jackson, J. (1998b). Is there a place for role theory in occupational science? *Journal of Occupational Science* 5(2), 56–65.
- Jonsson, H. (2007). *Towards a new direction in the conceptualization and categorization of occupation* [Wilma West Lecture, Occupational Science Symposium]. Los Angeles: University of Southern California, Occupational Science and Occupational Therapy.

- Kielhofner, G. (2002). Motives, patterns, and performance of occupation: Basic concepts. In G. Kielhofner (Ed.), *A model of human occupation: Theory and application* (3rd ed., pp. 13–27). Philadelphia: Lippincott Williams & Wilkins.
- Kramer, S., McGonigel, M., & Kaufmann, R. (1991). Developing the IFSP: Outcomes, strategies, activities, and services. In M. McGonigel, R. Kaufmann, & B. Johnson (Eds.), *Guidelines and recommended practices for the individualized family service plan* (2nd ed., pp. 41–49). Bethesda, MD: Association for the Care of Children's Health.
- Kronenberg, F., Algado, S. S., & Pollard, N. (2005). *Occupational therapy without borders: Learning from the spirit of survivors*. Philadelphia: Elsevier/Churchill Livingstone.
- Larson, E., & Zemke, R. (2004). Shaping the temporal patterns of our lives: The social coordination of occupation. *Journal of Occupational Science*, *10*, 80–89.
- Law, M., Baum, M. C., & Dunn, W. (2005). *Measuring occupational performance: Supporting best practice in occupational therapy* (2nd ed.). Thorofare, NJ: Slack.
- Law, M., Cooper, B., Strong, S., Stewart, D., Rigby, P., & Letts, L. (1996). Person–environment–occupation model: A transactive approach to occupational performance. *Canadian Journal of Occupational Therapy*, *63*, 9–23.
- Law, M., Polatajko, H., Baptiste, W., & Townsend, E. (1997). Core concepts of occupational therapy. In E. Townsend (Ed.), *Enabling occupation: An occupational therapy perspective* (pp. 29–56). Ottawa, ON: Canadian Association of Occupational Therapists.
- Liepmann, H. (1920). Apraxie. *Ergebnisse der Gesamten Medizin*, *1*, 516–543.
- Lopez, S. J., Snyder, C. R., Magyar-Moe, J., Edwards, L. M., Pedrotti, J. T., Janowski, K., et al. (2004). Strategies for accentuating hope. In P. A. Linley & S. Joseph (Eds.), *Positive psychology in practice* (pp. 388–404). Hoboken, NJ: John Wiley & Sons.
- Maciejewski, M., Kawiecki, J., & Rockwood, T. (1997). Satisfaction. In R. L. Kane (Ed.), *Understanding health care outcomes research* (pp. 67–89). Gaithersburg, MD: Aspen.
- Meyer, A. (1922). The philosophy of occupational therapy. *Archives of Occupational Therapy*, *1*, 1–10.
- Moreira-Almeida, A., & Koenig, H. G. (2006). Retaining the meaning of the words religiousness and spirituality: A commentary on the WHOQOL SRPB group's "A cross-cultural study of spirituality, religion, and personal beliefs as components of quality of life" (62:6, 2005, pp. 1486–1497). *Social Science and Medicine*, *63*, 843–845.
- Mosey, A. C. (1996). *Applied scientific inquiry in the health professions: An epistemological orientation* (2nd ed.). Bethesda, MD: American Occupational Therapy Association.
- Moyers, P. A. (1999). The guide to occupational therapy practice. *American Journal of Occupational Therapy*, *53*, 247–322.
- Moyers, P. A., & Dale, L. M. (2007). *The guide to occupational therapy practice* (2nd ed.). Bethesda, MD: AOTA Press.
- Neistadt, M. E., & Crepeau, E. B. (Eds.). (1998). *Willard and Spackman's occupational therapy* (9th ed.). Philadelphia: Lippincott Williams & Wilkins.
- Nelson, D., & Jepson-Thomas, J. (2003). Occupational form, occupational performance, and a conceptual framework for therapeutic occupation. In P. Kramer, J. Hinojosa, & C. Brasic Royeen (Eds.), *Perspectives in human occupation: Participation in life* (pp. 87–155). Philadelphia: Lippincott Williams & Wilkins.
- Nurit, W., & Michel, A. B. (2003). Rest: A qualitative exploration of the phenomenon. *Occupational Therapy International*, *10*, 227–238.
- Olsen, J. A. (2004). Mothering co-occupations in caring for infants and young children. In S. A. Esdaile & J. A. Olson (Eds.), *Mothering occupations* (pp. 28–51). Philadelphia: F. A. Davis.
- Parham, L. D., & Fazio, L. S. (Eds.). (1997). *Play in occupational therapy for children*. St. Louis, MO: Mosby.
- Pedretti, L. W., & Early, M. B. (2001). Occupational performance and model of practice for physical dysfunction. In L. W. Pedretti & M. B. Early (Eds.), *Occupational therapy practice skills for physical dysfunction* (pp. 7–9). St. Louis, MO: Mosby.
- Pierce, D. (2001). Untangling occupation and activity. *American Journal of Occupational Therapy*, *55*, 138–146.
- Punwar, A. J., & Peloquin, S. M. (2000). *Occupational therapy principles and practice* (3rd ed.). Philadelphia: Lippincott Williams & Wilkins.

- Radomski, M. V. (1995). There is more to life than putting on your pants. *American Journal of Occupational Therapy*, 49, 487–490.
- Reed, K. L. (2005). An annotated history of the concepts used in occupational therapy. In C. H. Christiansen, M. C. Baum, & J. Bass-Haugen (Eds.), *Occupational therapy: Performance, participation, and well-being* (3rd ed., pp. 567–626). Thorofare, NJ: Slack.
- Request for Planning Ideas for the Development of the Children's Health Outcomes Initiative, 66 Fed. Reg. 11296 (2001).
- Rogers, J. C., & Holm, M. B. (1994). Assessment of self-care. In B. R. Bonder & M. B. Wagner (Eds.), *Functional performance in older adults* (pp. 181–202). Philadelphia: F. A. Davis.
- Rogers, J. C., & Holm, M. B. (2008). The occupational therapy process: Evaluation and intervention. In E. B. Crepeau, E. S. Cohn, & B. A. B. Schell (Eds.), *Willard and Spackman's occupational therapy* (11th ed., pp. 478–518). Baltimore: Lippincott Williams & Wilkins.
- Schell, B. A. B., Cohn, E. S., & Crepeau, E. B. (2008). Overview of personal factors affecting performance. In E. B. Crepeau, E. S. Cohn, & B. A. B. Schell (Eds.), *Willard and Spackman's occupational therapy* (11th ed., pp. 650–657). Baltimore: Lippincott Williams & Wilkins.
- Schultz, S., & Schkade, J. (1997). Adaptation. In C. Christiansen & M. C. Baum (Eds.), *Occupational therapy: Enabling function and well-being* (p. 474). Thorofare, NJ: Slack.
- Segal, R. (2004). Family routines and rituals: A context for occupational therapy interventions. *American Journal of Occupational Therapy*, 58, 499–508.
- Shumway-Cook, A., & Wollacott, M. H. (2007). *Motor control: Translating research into clinical practice* (3rd ed.). Philadelphia: Lippincott Williams & Wilkins.
- Slagle, E. C. (1924). A year's development of occupational therapy in New York state hospitals. *Modern Hospital*, 22(1), 98–104.
- Sleep. (2007). *The free dictionary*. Retrieved June 1, 2007, from <http://freedictionary.org>
- Taber's cyclopedic medical dictionary*. (1997). Philadelphia: F. A. Davis.
- Townsend, E. A., & Wilcock, A. A. (2004). Occupational justice. In C. H. Christiansen & E. A. Townsend (Eds.), *Introduction to occupation: The art and science of living* (pp. 243–273). Upper Saddle River, NJ: Prentice Hall.
- Trentham, B., & Cockburn, L. (2005). Participating in action research: Creating new knowledge and opportunities for occupational engagement. In F. Kronenberg, S. S. Algado, & N. Pollard (Eds.), *Occupational therapy without borders: Learning from the spirit of survivors* (pp. 440–453). Philadelphia: Elsevier/Churchill Livingstone.
- Trombly, C. (1995). Occupation: Purposefulness and meaningfulness as therapeutic mechanism. *American Journal of Occupational Therapy*, 49, 960–972.
- Uniform Data System for Medical Rehabilitation. (1996). *Guide for the uniform data set for medical rehabilitation (including the FIM instrument)*. Buffalo, NY: Author.
- Weber, M. (1978). *Economy and society: An outline of interpretive sociology* (G. Roth & C. Wittich, Eds.; E. Fischoff et al., Trans.). Berkeley: University of California Press.
- Webster's encyclopedic unabridged dictionary of the English language*. (1994). Avenel, NJ: Gramercy Books.
- Wilcock, A. A. (2006). *An occupational perspective of health* (2nd ed.). Thorofare, NJ: Slack.
- Wilcock, A. A., & Townsend, E. A. (2008). Occupational justice. In E. B. Crepeau, E. S. Cohn, & B. B. Schell (Eds.), *Willard and Spackman's occupational therapy* (11th ed., pp. 192–199). Baltimore: Lippincott Williams & Wilkins.
- World Health Organization. (1986, November 21). *The Ottawa Charter for Health Promotion*. First International Conference on Health Promotion, Ottawa. Retrieved February 4, 2008, from <http://www.who.int/healthpromotion/conferences/previous/ottawa/en/print.html>
- World Health Organization. (2001). *International classification of functioning, disability, and health (ICF)*. Geneva: Author.
- Zemke, R. (2004). Time, space, and the kaleidoscopes of occupation [Eleanor Clarke Slagle Lecture]. *American Journal of Occupational Therapy*, 58, 608–620.
- Zemke R., & Clark, F. (1996). *Occupational science: An evolving discipline*. Philadelphia: F. A. Davis.

Zhan, L. (1992). Quality of life: Conceptual and measurement issues. *Journal of Advanced Nursing*, 17, 795–800.

Bibliography

Accreditation Council for Occupational Therapy Education. (2007a). Accreditation standards for a doctoral-degree-level educational program for the occupational therapist. *American Journal of Occupational Therapy*, 61, 641–651.

Accreditation Council for Occupational Therapy Education. (2007b). Accreditation standards for an educational program for the occupational therapy assistant. *American Journal of Occupational Therapy*, 61, 662–671.

Accreditation Council for Occupational Therapy Education. (2007c). Accreditation standards for a master's-degree-level educational program for the occupational therapist. *American Journal of Occupational Therapy*, 61, 652–661.

American Occupational Therapy Association. (1995). Occupation: A position paper. *American Journal of Occupational Therapy*, 49, 1015–1018.

Baum, M. C. (1999, November). *At the core of our profession: Occupation-based practice* [Overhead presentation]. Presented at the AOTA Practice Conference, Reno, Nevada.

Blanche, E. I. (1999). *Play and process: The experience of play in the life of the adult*. Ann Arbor: University of Michigan.

Blount, M. L., Blount, W., & Hinojosa, J. (2004). Perspectives. In J. Hinojosa & M. L. Blount (Eds.), *The texture of life: Purposeful activities in occupational therapy* (2nd ed., pp. 17–38). Bethesda, MD: AOTA Press.

Borg, B., & Bruce, M. (1991). Assessing psychological performance factors. In C. H. Christiansen & C. M. Baum (Eds.), *Occupational therapy: Overcoming human performance deficits* (pp. 538–586). Thorofare, NJ: Slack.

Borst, M. J., & Nelson, D. L. (1993). Use of uniform terminology by occupational therapists. *American Journal of Occupational Therapy*, 47, 611–618.

Buckley, K. A., & Poole, S. E. (2004). Activity analysis. In J. Hinojosa & M. L. Blount (Eds.), *The texture of life: Purposeful activities in occupational ther-*

apy (2nd ed., pp. 69–114). Bethesda, MD: AOTA Press.

Canadian Association of Occupational Therapists. (1997). *Enabling occupation: An occupational therapy perspective*. Ottawa, ON: CAOT Publications ACE.

Christiansen, C. H. (1997). Acknowledging a spiritual dimension in occupational therapy practice. *American Journal of Occupational Therapy*, 51, 169–172.

Christiansen, C. H., & Matuska, K. M. (2004). The importance of everyday activities. In C. H. Christiansen & K. M. Matuska (Eds.), *Ways of living: Adaptive strategies for special needs* (3rd ed., pp. 1–20). Bethesda, MD: AOTA Press.

Clark, F. A., Parham, D., Carlson, M. C., Frank, G., Jackson, J., Pierce, D., et al. (1991). Occupational science: Academic innovation in the service of occupational therapy's future. *American Journal of Occupational Therapy*, 45, 300–310.

Clark, F. A., Wood, W., & Larson, E. (1998). Occupational science: Occupational therapy's legacy for the 21st century. In M. E. Neistadt & E. B. Crepeau (Eds.), *Willard and Spackman's occupational therapy* (9th ed., pp. 13–21). Philadelphia: Lippincott Williams & Wilkins.

Culler, K. H. (1993). Occupational therapy performance areas: Home and family management. In H. L. Hopkins & H. D. Smith (Eds.), *Willard and Spackman's occupational therapy* (8th ed., pp. 207–269). Philadelphia: Lippincott Williams & Wilkins.

Dunn, W., Brown, C., & McGuigan, A. (1994). The ecology of human performance: A framework for considering the effect of context. *American Journal of Occupational Therapy*, 48, 595–607.

Gardner, H. (1999). *Intelligence reframed: Multiple intelligences for the 21st century*. New York: Basic Books.

Hill, J. (1993). Occupational therapy performance areas. In H. L. Hopkins & H. D. Smith (Eds.), *Willard and Spackman's occupational therapy* (8th ed., pp. 191–268). Philadelphia: Lippincott.

Hinojosa, J., & Blount, M. L. (2004). Purposeful activities within the context of occupational therapy. In J. Hinojosa & M. L. Blount (Eds.), *The texture of life: Purposeful activities in occupational ther-*

- apy (2nd ed., pp. 1–16). Bethesda, MD: AOTA Press.
- Holm, M. B., Rogers, J. C., & Stone, R. G. (1998). Treatment of performance contexts. In M. E. Neistadt & E. B. Crepeau (Eds.), *Willard and Spackman's occupational therapy* (9th ed., pp. 471–517). Philadelphia: Lippincott Williams & Wilkins.
- Horsburgh, M. (1997). Towards an inclusive spirituality: Wholeness, interdependence, and waiting. *Disability and Rehabilitation*, *19*, 398–406.
- Intagliata, S. (1993). Rehabilitation centers. In H. L. Hopkins & H. D. Smith (Eds.), *Willard and Spackman's occupational therapy* (8th ed., pp. 784–789). Philadelphia: Lippincott.
- Kane, R. L. (1997). Approaching the outcomes question. In R. L. Kane (Ed.), *Understanding health care outcomes research* (pp. 1–15). Gaithersburg, MD: Aspen.
- Kielhofner, G. (1992). *Conceptual foundations of occupational therapy*. Philadelphia: F. A. Davis.
- Kielhofner, G. (2002). Habituation: Patterns of daily occupation. In G. Kielhofner (Ed.), *Model of human occupation: Theory and application* (3rd ed., pp. 63–80). Philadelphia: Lippincott Williams & Wilkins.
- Law, M. (1991). The environment: A focus for occupational therapy. *Canadian Journal of Occupational Therapy*, *58*, 171–179.
- Law, M. (1993). Evaluating activities of daily living: Directions for the future. *American Journal of Occupational Therapy*, *47*, 233–237.
- Law, M. (1998). Assessment in client-centered occupational therapy. In M. Law (Ed.), *Client-centered occupational therapy* (pp. 89–106). Thorofare, NJ: Slack.
- Lifson, L. E., & Simon, R. I. (Eds.). (1998). *The mental health practitioner and the law: A comprehensive handbook*. Cambridge, MA: Harvard University Press.
- Llorens, L. (1993). Activity analysis: Agreement between participants and observers on perceived factors and occupation components. *Occupational Therapy Journal of Research*, *13*, 198–211.
- Ludwig, F. M. (1993). Anne Cronin Mosey. In R. J. Miller & K. F. Walker (Eds.), *Perspectives on theory for the practice of occupational therapy* (pp. 41–63). Gaithersburg, MD: Aspen.
- Mosey, A. C. (1981). Legitimate tools of occupational therapy. In A. Mosey (Ed.), *Occupational therapy: Configuration of a profession* (pp. 89–118). New York: Raven.
- Mosey, A. C. (1986). *Psychosocial components of occupational therapy*. New York: Raven.
- Nelson, D. L. (1988). Occupation: Form and performance. *American Journal of Occupational Therapy*, *42*, 633–641.
- Pierce, D. (1999, September). Putting occupation to work in occupational therapy curricula. *Education Special Interest Section Quarterly*, *9*(3), 1–4.
- Pollock, N., & McColl, M. A. (1998). Assessments in client-centered occupational therapy. In M. Law (Ed.), *Client-centered occupational therapy* (pp. 89–105). Thorofare, NJ: Slack.
- Reed, K., & Sanderson, S. (1999). *Concepts of occupational therapy* (4th ed.). Philadelphia: Lippincott Williams & Wilkins.
- Schell, B. B. (1998). Clinical reasoning: The basis of practice. In M. E. Neistadt & E. B. Crepeau (Eds.), *Willard and Spackman's occupational therapy* (9th ed., pp. 90–100). Philadelphia: Lippincott Williams & Wilkins.
- Scherer, M. J., & Cushman, L. A. (1997). A functional approach to psychological and psychosocial factors and their assessment in rehabilitation. In S. S. Dittmar & G. E. Gresham (Eds.), *Functional assessment and outcomes measurement for the rehabilitation health professional* (pp. 57–67). Gaithersburg, MD: Aspen.
- Urbanowski, R., & Vargo, J. (1994). Spirituality, daily practice, and the occupational performance model. *Canadian Journal of Occupational Therapy*, *61*, 88–94.
- Watson, D. E., & Wilson, S. A. (2003). *Task analysis: An individual and population approach* (2nd ed.). Bethesda, MD: AOTA Press.
- Yerxa, E. J. (1980). Occupational therapy's role in creating a future climate of caring. *American Journal of Occupational Therapy*, *34*, 529–534.

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